The lived experience of critical care nurses transitioning into an Advanced Critical Care Practitioner role – an Interpretative Phenomenological Analysis.

By

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Abstract

Advanced practice roles are increasingly being introduced in response to changing healthcare needs and service/ workforce demands. Ongoing debate regarding the nature and paradigm positioning of advanced practitioners continues, particularly for roles such as the Advanced Critical Care Practitioner. This role has evolved and is operationalised within the medical framework although it is undertaken by registrants from other professional backgrounds who may bring their own values to the role. This study is the first to investigate the lived experience of critical care nurses who transition into Advanced Critical Care Practitioner roles, with particular focus on nurses' perceptions and construction of their own professional identity and positionality within the wider healthcare team following the transition.

Adopting an Interpretative Phenomenological Analysis methodology facilitated the focus on the lived experience and lifeworld of each participant. Eight semi-structured interviews were conducted with purposively recruited nurse Advanced Critical Care Practitioners from across the United Kingdom. Consistent with the philosophical principles of Interpretative Phenomenological Analysis, idiographic interpretation of individual experiences was completed, prior to cross-case analysis which sought to discover convergence and divergence.

Three Group Experiential Themes have emerged which answer the research question:

1. *"An explosion of a role" – navigating the transition*
2. *"There to care" – negotiating their identity and place*
3. *"I think it will get better, won't it?" – vulnerability, concern and hope*

Drawing on Bourdieu's conceptual thinking tools (1990; 2000), the concept of hysteresis has provided a framework for understanding the change to the nurses' own habitus, identity and sense of positionality within the field. Transition was compounded by a complexity of personal, situational and professional factors. Both the inter- and intra-relational encounters with other members of the nursing and medical teams directly impacted on the participants. Of significance was the level of disconnection and disruption experienced between the participants and other nurses, particularly senior nurses. However, participants employed strategies to utilise their nursing identity and habitus, creating a hybrid position which enables them to draw on both paradigms of nursing and medical practice in their Advanced Critical Care Practitioner role.

This study offers a novel insight into how nurses transition into advanced practice roles, particularly for roles with a stronger medical identity such as the Advanced Critical Care Practitioner role. It

challenges the critical view that such roles are sought by professionals who want to attain a greater medical positioning, thus leaving their heritage identity behind. The findings offer a range of recommendations for professional nursing practice, organisational workplace culture and planning, and research in consideration of nurses' professional identity, support and positionality within the healthcare team.

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Abbreviations

ACCP (tACCP)	Advanced Critical Care Practitioner (trainee ACCP)
ACP	Advanced Clinical Practitioner
AfC	Agenda for change (Pay scale used within the NHS).
AHP	Allied Health Practitioner
ANP	Advanced Nurse Practitioner
BACCN	British Association of Critical Care Nurses
CC3N	Critical Care Networks – National Nurse Leads
CCOT	Critical Care Outreach Team
CPD	Continual Professional Development
DH / DHSC	Department of Health / Department of Health and Social Care
ENB	English National Board
ENP	Emergency Nurse Practitioner
EWTD	European Working Time Directive
FICM	Faculty for Intensive Care Medicine
F1 /F2	Foundation Year 1 resident doctor / Foundation Year 2 resident doctor
GMC	General Medical Council
GPICS	Guidelines for the Provision of Intensive Care Services
HCPC	Health and Care Professions Council
HDU	High Dependency Unit
HEE	Health Education England
HEI	Higher Education Institutes
ICM	Intensive Care Medicine
ICM Consultants	Intensive Care Medicine Consultants
ICS	Intensive Care Society
ICU	Intensive Care Unit (Also called Critical Care Unit)
ITU	Intensive Therapy Unit (Also called Critical Care Unit)
KSBs	Knowledge, skills and behaviours
MAP	Medical Associate Professions
MDT	Multidisciplinary Team
NHS	National Health Service
NHSE	NHS England
NICE	National Institute for Health and Care Excellence
NMC	Nursing and Midwifery Council
NMP	Non-medical prescribing / prescriber
NP	Nurse Practitioner
RCEM	Royal College of Emergency Medicine
RCN	Royal College of Nursing
RCP	Royal College of Physicians
SR/ Reg	(Specialist) Registrar – a doctor who has completed the 2-year Foundation training and is now training towards Consultant.
UKCC	United Kingdom Central Council for Nursing, Midwifery and Health Visting
WHO	World Health Organisation

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Chapter 1 Introduction to the thesis

Introduction

The development of advanced nursing roles has evolved over several decades in the United Kingdom. Advanced nursing roles are evident across a multitude of clinical specialities, including critical care, as a result of internal professional drivers as well as external political drivers (Leary and MacLaine, 2019; Swaby et al., 2022). Changing patient demographics, the subsequent increasing demands for healthcare, changes to the medical workforce, and the impact of wider economic pressures have required the National Health Service (NHS) to respond. This has led to the development of innovative workforce solutions, such as advanced practice roles, subsequently shifting traditional workforce roles and boundaries. Nurses have therefore been enabled to develop and advance their scope of professional practice and undertake care previously considered to be outside the domain of nursing (Diamond-Fox and Stone, 2021; Unsworth et al., 2022).

Nadaf (2018) and Thompson et al. (2020) argue that in some instances advanced practice roles are viewed purely as substitution roles or 'gap-fillers' for shortages in the medical workforce. Roles which are constructed and aligned to specific medical body standards and accreditation are particularly viewed as driven by the need to use advanced practitioners to provide a replacement role (Ablard et al., 2025; Gray, 2016). Examples of such roles include Advanced Clinical Practitioners (ACPs) working in Emergency Departments or similar environments, who can gain accreditation with The Royal College of Emergency Medicine (RCEM), or Advanced Critical Care Practitioners (ACCPs) who can seek membership of the Faculty of Intensive Care Medicine (FICM). This perspective is in opposition of the view that advanced practice roles originate and further promote the values, expert knowledge and practice of the nurse, or other registered healthcare professional who may undertake advanced level practice (Barratt, 2022; Nadaf, 2018).

ACCP's are described as highly experienced and educated non-medical clinical professionals, including nurses, physiotherapists and paramedics, who assess, diagnose, and deliver intensive care medicine to the critically ill patient (Faculty of Intensive Care Medicine, 2021b; Intensive Care Society, 2022). Whilst demand for the role has grown, criticism has included a lack of understanding of the role by the post-holders as well as the wider healthcare team, and as well as a perceived loss of nurses from the nursing workforce (Horsfield, 2020; Lee et al., 2018). This type of advanced level role also creates a question as to how the post-holder positions themselves and their underpinning professional practice and identity, in relation to the wider multi-professional healthcare team.

Therefore, this phenomenological study explores the experiences of critical care nurses in the United Kingdom (UK) who have made the transition to practice as an Advanced Critical Care Practitioner (ACCP). The study intentionally focusses on nurses in ACCP roles as they form the majority professional group in ACCP roles (Denton et al., 2023). In addition, my own professional background and experience, as explained later in this chapter, has influenced my interest in this distinct area of nursing practice.

The research explores the lived experience of the nurses from their decision to leave their substantive critical care nursing post, to undertake the training to gain the ACCP qualification, and through their process of transitioning fully into this role. It seeks to discover how the ACCPs perceive their own professional identity following the transition, particularly regarding their nursing identity and whether this is still salient for them. Furthermore, the research seeks to understand how they have established themselves as an ACCP in the wider healthcare team, and how their professional relationships with others may have changed.

To ensure congruence with the epistemological and philosophical underpinnings of this study, the thesis will be written in the first person, situating myself as the researcher within the research. This chapter will commence by outlining my professional background and interest in the areas of critical care nursing and advanced practice education. The evolution of the research aim and question will be outlined. The chapter will conclude with an outline of the structure of the thesis.

The origins of the study

My interest in this area of study has derived from the two major paradigms of my professional nursing career, that of being a critical care nurse and more recently as an advanced practice educator working within Higher Education. As a registered nurse with over 30 years' experience, working in intensive care, I immediately felt drawn to ensure my research was related to this specialty. Working within intensive care provided the opportunity for my professional nursing practice to develop. I mastered specialist knowledge and skills which could be described as expanded or extended against what is construed as general nursing practice. As my career and experience progressed, I gained the role of critical care Professional Development Nurse (PDN), a role that focused on the provision, delivery and evaluation of education and professional development processes for the critical care nursing team. As

part of the senior nurse team, this role ensured professional and specialist standards that influenced the provision of critical care nursing were maintained. This part of my career provided great professional satisfaction, particularly as I participated in supporting novice junior nurses to grow and advance their careers, achieving post-graduate qualifications, developing high quality nursing skills and knowledge, and for some, progress into senior nursing roles. Within my time working in clinical practice, the concepts of advanced level nursing practice were becoming more integrated within critical care, with the appointment of a Nurse Consultant as well as the establishment of a Critical Care Outreach team. These will be explored more in Chapter 2.

As a nurse educator moving from a clinical to a university setting, I was able to continue to provide acute and critical care focused teaching and learning activities for under-graduate and post-graduate nursing students. Despite my experience and academic qualifications, I experienced a range of challenges during the initial stages of my transition into a new career, notably a drop in confidence, and feelings that I had made an error in changing roles. This was emphasised by a sense of not belonging, not speaking the same (academic) language as everyone else, and to some extent by my own self-doubt. It was sometime later that I appreciated that my experience was not unique to myself, and that the phenomena of transition and the associated shift in professional identity when changing roles has been noted within the evidence base (Harper-McDonald and Taylor, 2020; Logan et al., 2016).

In due course, I was asked to join the advanced practice academic team to provide a specialist acute and critical care nursing perspective, and a few years after this, I became the Course Lead for advanced practice courses offered by the University. Both changes in role brought back the sense of feelings I had experienced when becoming an academic, albeit to a lesser extent. A core responsibility of my Course Lead role is to engage with local and national initiatives, and to collaborate with advanced practice professional groups, such as the Association of Advanced Practice Educators UK (AAPE UK), and the Midlands Higher Education Institution Advanced Clinical Practice Advisory Group (MHEIACPAG). On a national and local level, these groups provide an established network to share information and best practice, and to provide a consensus for raising issues to policy makers, employers and NHS England in matters relating to the provision of advanced practice education and standards. Being a member of these organisations allows the opportunity to maintain educational credibility and ensures responsiveness to the often fast-paced changes to standards, evidence and strategic policies associated with advanced level practice. Since the publication of the '*Multi-*

professional framework for advanced clinical practice'[1] in England (Health Education England, 2017), the field of advanced practice in the context of UK healthcare has developed and shifted exponentially, bringing a number of clear benefits as well as some professional challenges for those involved with advanced practice roles. Chapter 2 explores this more fully against the context of the wider development of nursing and advanced level practice.

Drawing together these two core fields of my professional career - critical care nurse and an advanced practice educator - a third professional identity has evolved, that of a doctoral student researcher. My transition into this new identity has been turbulent at times, as I have both thrived and struggled, particularly losing confidence during more challenging periods. Green (2016) identified the potential for professionals to experience identity changes when undertaking doctoral research, which is suggestive of the concept of 'imposter syndrome', a phenomenon in which a person struggles to recognise their success or achievements as being deserved (Clance and Imes, 1978). To counter this, from the onset of the doctorate process, my development and progression as a researcher has been enhanced through engaging in critical reflection, helping to capture thoughts, feelings, challenges and opportunities which emerged during this study (Harvey and Howard-Hunt, 2021). As a registered nurse, reflection is an essential element of professional practice, and a requirement of revalidation as a registrant (Nursing and Midwifery Council, 2024b), and so I am familiar with its importance to my professional practice. Importantly, as a novice researcher, reflection is a process which allowed me to understand my own behaviours, attitudes, and experiences, enabling me to remain self-aware and analytical throughout the process (Clarke, 2024).

My initial ideas on commencing the first year of the doctorate were exploring the similarities and differences between different advanced practice roles in critical care. However, as I have moved forward in my immersion in the relevant literature, I became aware that several of my previous critical care nursing colleagues were considering applying for trainee ACCP posts. I had not worked in a critical care service which had integrated ACCPs into the workforce, although I was aware of the role and the implementation within other NHS Trusts. I understood that the ACCP role development, implementation and professional governance was managed within the critical care medical hierarchy, and the emergence of the role might have been driven by a shortage of doctors (Denton et al., 2023; Lee et al., 2018). A recurring question I had at that time was what would the motivation be for nurses

[1] This was updated in 2025: NHS England (2025b) *Multi-professional framework for advanced practice in England.* London. Both versions will be referred to at different times in the thesis.

to undertake this type of advanced level role, with duties that had previously been situated in the medical domain? At that time, it was difficult to understand what the appeal was for nurses to undertake this shift in career direction. I considered these former colleagues to be excellent, experienced critical care nurses who possessed a wealth of skills and knowledge and provided clinical leadership to the wider nursing workforce. As a registered nurse, I became increasingly curious about why other nurses perceived this role to be appealing, and what it was like for them to make such a change in career. Drawing on my own experience of undergoing a professional role transition, I also wanted to understand if moving from an established role in nursing into this new role could affect how they viewed their professional identity and positionality within the traditional critical care workforce. An initial limited scoping of the published literature underlined that this was a topic without a clear evidence base to explain it. As a result, this research is primarily concerned with the individual lived experience of critical care nurses transitioning to an ACCP role.

As a critical care nurse myself, I recognised the importance of being able to interrogate my own pre-conceptions, biases and assumptions drawn from my prior knowledge and experiences, throughout the whole of the research process (Smith et al., 2022; Willig, 2022). Reflexivity, the process of exploring oneself, and reflecting on how as the researcher I am influencing the research process aids in developing personal self-awareness and provides a method for enhancing the quality and trustworthiness of the findings (Peddle, 2022). During the experience of being a doctoral student, I would revisit notes and draft work made at the start of the process. This allowed me to recognise shifts in my thinking as I developed confidence as a researcher. This unstructured initial period of developing awareness of myself as a researcher evolved into a more distinct reflexive journalling process, as I moved through the stages of the research study. To promote research transparency and integrity, personal reflection and reflexivity will be demonstrated throughout the thesis, to promote reader confidence in the interpretation of the findings. The reflexive process has commenced within this Introduction chapter, as I set out my position and interest in the subject area. A more detailed exploration of reflexivity will be provided in relation to the design and execution of the research (Chapter 5), as well as a final critical reflection on the research process and my role as the researcher (Chapter 10). In addition, extracts of reflection and reflexivity will be evidenced at different junctures within the thesis.

The research problem – significance and justification

In addition to personal curiosity, it is necessary to establish a clear need for this research in a wider context, to show that the study will have wider significance at this time. NHS policies, such as the *NHS*

Five Year Forward View (NHS England, 2014), *Next steps on the NHS Five Year Forward View* (NHS England, 2017), *The NHS Long Term Plan* (NHS England, 2019), the *People Plan 2020/21* (NHS England, 2020), and *Fit for the Future: the 10 year health plan for England (NHS England, 2025a)* recognise the concerns about funding, staffing and the changing demands for healthcare services. To address these issues, the policies advise on the need for service redesign and workforce development including new advanced practice nursing roles. The nature, preparation, governance and integration of such roles into the workforce all need to be considered, as potential and actual concerns are evident in the current climate (which will be discussed further in Chapters 2 and 3).

The nursing profession forms the largest group in the National Health Service (NHS) workforce of over 1.3 million people, with almost three times more nurses than doctors (NHS Digital, 2022). However, data from NHS England and NHS Improvement show a vacancy rate of over 25,000 whole time equivalent (WTE) registered nurses in March 2025. Within critical care nursing, job vacancies are also growing, particularly amongst senior and experienced nurses (Faculty of Intensive Care Medicine, 2021b). Turnover of staff has been reported as high as 42% in some regions, attributed to higher levels of staff leaving the workforce, for example due to an ageing workforce or higher stress and health related issues (Cutler et al., 2021). This has led to a corresponding increase in the use of Bank or Agency staffing, and an increase in overseas recruitment of nurses, thus further diluting the skill mix and expertise of the nursing workforce.

A more recent significant impact on the wider critical care service has been the unprecedented surge in demand as a result of the *Severe Acute Respiratory Syndrome coronavirus 2* (SARS-CoV-2, which is also referred to as Covid-19). The effect of Covid-19 on those working in critical care is still to be fully understood but research shows a detrimental impact on staff well-being, retention and workforce structures (Endacott et al., 2022; Montgomery et al., 2021). More recently, a national survey of critical care nurses found that 49% of respondents were planning to leave their roles in the next three years (Critical Care National Nurse Leads (CC3N), 2022). The study highlighted different reasons for this but lack of pay recognition and unclear career opportunities rated highly. Reflecting this, a study to explore the policy and research priorities of global critical care organisations found education and issues relating to nursing workforce retention a high priority (Williams et al., 2023). The movement of nurses from the nursing workforce into ACCP roles could be seen as contributing to the growing issue with retention of experienced staff. The number of qualified ACCPs registered with FICM was 322 in early 2023, with almost half again in trainee roles, which reflects an increasing proliferation of the role since

its inception (Denton et al., 2023). It is therefore necessary to explore why this role is viewed as attractive for senior critical care nurses.

As such, this research will contribute new evidence to the wider body of nursing research which is concerned with advanced level nursing roles. It will seek to further empower nursing as a profession, and provide insight into the construction, deployment and impact of these types of advanced practice roles in the healthcare environment.

The research aim and purpose

The overarching aim of this research study is to explore the lived experiences of critical care nurses who have chosen to undertake a transition from their previous nursing role into that of an ACCP.

'What is the lived experience of critical care nurses who undertake the transition into an ACCP role?'

Three initial objectives for the research were formulated:

1. To discover how critical care nurses perceive and navigate influencing factors during and following their experience of the transition into the ACCP role.
2. To explore how critical care nurses view their own professional identity and positionality within the healthcare team through their lived experiences of the transition into the ACCP role.
3. To formulate recommendations for future ACCPs, employers, workforce planners and education institutes to promote successful application of this role to meet the demands of critical care services.

The organisation of the thesis

This thesis is divided into 10 related chapters. Chapters 1 to 3 explore the background and the wider historical, professional, political and empirical contexts associated with nursing and advanced practice, as well as an orientation to the speciality of critical care. Chapters 4 to 6 detail the methodological and practical approach that structures this research, specifically the methodology, the design of the research process, and the mechanism taken for data analysis. The remaining Chapters 6 to 10 outline the study findings, the discussion and finally the conclusion with recommendations. The content of the chapters is outlined below.

Chapter 1: Introduction

This chapter sets the scene for the research by presenting the origins of the study. My positioning is presented in relation to professional, clinical and academic professional reflections. These lead to clarification and justification of the research aim and objectives.

Chapter 2: Background – the context of the study

Contextual background relating to the key areas of interest for this research, specifically nursing, critical care nursing and advanced nursing practice is provided in this chapter. The emergence of nursing as a modern profession, and the development of advanced level practice is explained in conjunction with relevant historical, professional and contemporary healthcare and policy considerations. The provision of critical care within the UK National Health Service (NHS), and the nature of critical care nursing is discussed. Following this, advanced level practice roles within critical care, with a focus on the emergence and implementation of the ACCP role will complete the exploration of the fields of interest.

Chapter 3: Literature review

The rationale and strategies for undertaking a scoping literature review is outlined and justified. Literature pertaining to three core areas of enquiry - the transition into advanced practice roles; professional identity; positionality and professional relationships - is explored and summarised to situate my research within a broader context, and to evidence gaps in the research. This justifies the need for this study and demonstrates where an original contribution can be made.

Chapter 4: Methodology

This chapter provides a critical discussion of my ontological and epistemological positioning as the researcher. The methodological approach chosen is outlined and explained. This is followed by a discussion justifying a qualitative approach, specifically Interpretative Phenomenological Analysis (IPA) as the most suitable methodology to answer the research question. Exploration of other qualitative approaches and the rationales for not using these will be given.

Chapter 5: Methods

This chapter details the research design employed in this study which has been informed by the theoretical underpinnings of IPA. The methods for the sampling of participants and data collection

through semi-structured interviews are justified. Details of research quality assurance and governance processes, as well as ethical principles are provided.

Chapter 6: Data analysis

Here, details outlining the analysis of the data is provided in a separate chapter to reflect the detail and attention given to this stage of the study. Analysis has been guided by the framework provided for IPA researchers (Smith et al., 2022), which ensures an idiographic, single case focus before consideration of cross-case analysis.

Chapter 7: Findings – the individual participants' experiences

This chapter provides detail of the findings from the idiographic analysis of all eight participant interview transcripts. Each participant Personal Experiential Themes (PET) and sub-themes are presented and discussed individually to explore their experiences and meaning of their own transition into an ACCP role.

Chapter 8: Findings – cross case experiences

Chapter 8 presents the findings from the cross-case analysis of the participant experiences, which has led to the formation of three Group Experiential Themes (GET) themes and sub-themes. These are presented and discussed, with extracts from the participants interviews providing evidence for each.

Chapter 9: Discussion

This chapter explores the findings, situating these against existing research, and other literature such as policy and professional guidelines or standards. Consideration and relevance of theoretical concepts relating to the key areas will also be discussed.

Chapter 10: Conclusion, recommendations and reflections

In this final chapter, the original contribution to knowledge and practice are presented. Recommendations for practice and education, and suggestions for future research are provided. An evaluation of the quality of the study, and final reflections of the doctoral process conclude this chapter.

Chapter 2 Background – the context of the study

Introduction

This chapter provides the background and context for framing this study. To begin with an exploration of the history and constructs of nursing, specifically the concepts of professions / professionals, and professional identity, is discussed. Advanced level practice in nursing will then be explored, with consideration of influential professional and policy drivers. The study is set in critical care, therefore the evolution and provision of care for critically ill patients in the United Kingdom is explained. Following this, exploration of the nursing role within critical care will be presented. Finally, the chapter will conclude with the examination of advanced level practice within critical care nursing, with a focus on the development and implementation of Advanced Critical Care Practitioner roles.

Nursing

A historical perspective

Historically, nursing was perceived as an unskilled role for women who undertook 'dirty work', often in charity hospitals and workhouses, typically with duties being caried out by lower social classes or inmates of the workhouses (Wild, 2018). Florence Nightingale is generally attributed as the founder of modern nursing. Following her time nursing injured soldiers in the Crimean War, on her return she wrote '*Notes on nursing*' in which she set out her philosophy of nursing, and in particular her belief that nurses should be formally educated to provide sound theoretical basis for their care (Wild, 2018). These beliefs formed the underpinning principles for the establishment in 1860 of the first recognised training school for nurses at St Thomas's Hospital, in London. This helped to set out nursing as a more reputable choice for Victorian women, creating a vocation which was governed by expectations of an individual's character, such as humility, servitude, being self-sacrificing, and sobriety (Bradshaw, 2017). Although Nightingale was an early advocate for nurses to have some form of training, this was typically determined and delivered by doctors, which ensured that they maintained control of what nurses knew and were permitted to do. This firmly placed nursing as being subordinate to the medical doctors, reinforcing that they were there to support, to act on their instructions and effectively be their 'handmaidens' (Wild, 2018).

According to Darbyshire and Thompson (2018), it is nurses' relationships with doctors that has generated debate over many years. In 1968, Stein introduced the concept of the 'doctor-nurse game' which held the doctor as the prime decision maker (the dominant team member) with the nurse expected to be passive and unchallenging, and so was seen to be maintaining the status quo of power

(Lewis, 2022). The concept that nursing is purely a vocational occupation under the command of medicine has been diminished through the development of unique nursing theory and evidence-based practice (Rosser, 2016). A significant shift in strengthening nursing as a profession came with the reform of nurse education proposed in the Project 2000 programme by the then UK nursing regulator, the United Kingdom Central Council (UKCC) (Maxwell, 2023). The proposals set out in the Project 2000 programme included the introduction of supernumerary status for student nurses, and the move of nurses education from a hospital-based provision into higher education, thereby giving emphasis on developing nurses who had been educated to diploma level, and who were active in seeking research or evidence to underpin their practice (Bradshaw, 2017; Maxwell, 2023). Whilst undoubtedly this strengthened the position of nursing in the healthcare team, there remained a lack of professional and academic parity with other professional groups, notably medicine. Shifts in policy which promote greater teamwork and multiprofessional or interprofessional learning and collaboration have helped to reduce the traditional hierarchical status (Lewis, 2022), although distinct professional structures and positioning remain evident (Khalili and Price, 2022). The value of nursing knowledge and expertise was further enhanced with a change to the standards for nurse education which, from 2013, required all newly qualified nurses in the UK to be educated to degree level (Nursing and Midwifery Council, 2010), although some 10 years later, the proportion of non-degree level registered nurses remaining in the workforce is not fully known.

An emerging profession

The implementation of the graduate level nursing qualification has forged the way in strengthening attempts to professionalise nursing, and to move it away from its historic subservient position. However, concerns about this change emerged within nursing, and within wider society. Notably there was a perception that graduate nurses would be 'too posh to wash' or 'too clever to care', an inference that nursing would lose its focus on direct patient care (Snee et al., 2020). The publication of '*Quality with Compassion: the future of nursing education. Report of the Willis Commission*' (Willis Commission, 2012) had firmly underlined the necessity of higher level education of nurses to meet the growing complexity of modern healthcare requirements, with the report confirming that there had been no evidence to support that graduate nurses were less caring or competent. Lord Willis went further, stating that it was "totally illogical" (Willis Commission, 2012: 4) to conflate higher level education to reduced caring and compassion, specifically as this was not a view levelled against other graduate healthcare professionals, such as doctors or physiotherapists. Currently, the requirements of nursing is framed by the Standards of Proficiency (Nursing and Midwifery Council, 2018a), and all nurses

currently registered with the NMC must demonstrate these, as well as adhere to expected standards and behaviours set out within The Code (Nursing and Midwifery Council, 2018c).

Nursing is complex and multi-faceted. Contemporary nursing practice, described as the 'art and science of nursing', reflects the need for scientific knowledge and technical skills, whilst ensuring a person-centred, caring and therapeutic outlook for patients or service users (McCaffrey, 2024). Raising the academic status to degree level characterises nursing as having a more critical perspective, informed by research and evidence-based theory to underpin practice, a key component in how a profession is defined (Timmins et al., 2022). The nature of what defines a group as being a profession can be drawn from a range of work but consensus is that it requires legitimisation to practice, with registration or regulation to ensure that individuals are held to a standard (Abbott, 1988; Brandsen et al., 2010; Willetts and Clarke, 2014). Professionalisation is seen as the process undertaken to form and close an occupational group in order to protect its own interests and specific practice (Evetts, 2013). This in turn establishes jurisdiction (Ernst, 2020), which for nurses infers a monopoly on the specific practice of nursing.

Integration into a profession, and the discourse on professional identity has been firmly rooted in how individuals in specific professional groups develop and establish their identity, which can be summarised as considering 'who we are' (Caza et al., 2018; Monrouxe, 2010). Professional identities are reinforced through professionalisation (Cain et al., 2019) and it has been shown that the development and maintenance of distinct professional identity is essential to the respective professional groups. In other words, professional identity is part of an individual's overall identity and is rooted in how individuals define themselves in relation to their work role, and specifically their behaviours, values, beliefs, knowledge, skills, and experiences (Best and Williams, 2019; ten Hoeve et al., 2014). Socialisation is a key element in the formation of professional identity (Joynes, 2018) and can be achieved through both formal and informal processes (Moradi et al., 2017). Some individuals may have pre-conceived ideas, values and opinions in relation to the professional group they aspire to join, but for many healthcare professionals, formal socialisation commences during the initial educational preparation for the chosen professional qualification and the attainment of the specific theory and constructs of the professional qualification (Moradi et al., 2017). Conversely, it is evident that some aspects of professional identity formation are only learned through exposure to experiential learning rather than being specifically taught (Joynes, 2018). Described as 'hidden' or informal socialisation, development of tacit behaviours and learning occurs through exposure to organisational culture and professional communities of practice (Hunter and Cook, 2018). These concepts are

reflected in the nursing literature. The development of professional identity for nurses occurs throughout their lifetimes, starting prior to entering the nursing profession, continuing during their pre-registration education, before becoming embedded as their clinical practice and experience develops throughout their careers (Hill, 2023). Rasmussen et al. (2021) suggest that a nurses professional identity continues to be embedded and enhanced as their knowledge, skills and confidence in their practice grows. In addition, Hunter and Cook (2018) found that professional socialisation and formation of identity is enhanced through positive role-modelling and support during the transition into a new role.

The positioning of the profession of nursing has been challenged with the emergence of new roles, such as assistant practitioners, clinical support workers and nursing associates (NA), who all provide elements of care associated with traditional nursing roles (Imison et al., 2016; Peate, 2023). The NA role has been regulated by the NMC since 2019, affording it a status within the nursing workforce, with its own standards of proficiency which outline the knowledge and skills required (Nursing and Midwifery Council, 2018b). However, concerns about the implementation of the role persist, notably that employers are substituting registered nurse vacancies with a cheaper nursing associate role (Dean, 2023b; Trueland, 2018). Additionally, concerns about 'role creep', where NA's are being expected to undertake practice outside of their remit have also been raised (Sumnall and Macwan, 2024; Trueland, 2018), giving rise to a call for better organisational readiness to ensure support, governance and clarity of what the role is (Thurgate and Griggs, 2023). Ironically, many of the same issues are also evident at the advanced level of nursing practice, which will now be explored.

Advanced practice development in the UK

Historical development of advanced nursing roles

Advanced level nursing practice has been evident in UK and international healthcare for several decades (Barton and Allan, 2015). Advanced practice is broadly described as a level of practice which goes beyond the level of practice gained at the point of registration, by working in an expanded way not traditionally associated with that profession (McGee and Inman, 2019). In the United States of America (USA), Nurse Practitioner (NP) roles were established in the early 1960's, as a response to the need for medical care for people in rural areas where there was a reduction in the availability of medical doctors (Schrober et al., 2016). By the early 1990's other countries such as Canada and Australia had developed and implemented similar advanced practice roles (King et al., 2017), and since then the demand for nurses to work at an advanced level has significantly grown globally although

there is variance in the scope of practice, educational preparation, and organisational infrastructure between many countries (International Council of Nurses, 2020).

Early advanced practice in the UK is often attributed to Barbara Stilwell who piloted a Nurse Practitioner role in primary care in Birmingham in the early 1980's (Stilwell, 1982). Stilwell's Nurse Practitioner role was developed to address deficits in the provision of and access to healthcare services for marginalised women, uniquely blending elements of the medical role (such as examination, diagnosis, and leading treatments) with nursing (Hill, 2017). Since then, advanced practice roles continued to emerge, with a range of policies, guidelines, frameworks and professional body standards contributing, with varying impact, on the evolution of advanced level practice in the UK. Table 1 outlines the historical policy and drivers for advanced level practice in the UK (preceding the publication of the '*Multi-professional framework for advanced clinical practice'* in England (Health Education England, 2017). Notably, the four countries of the United Kingdom – England, Wales, Scotland and Northern Ireland – have developed independent standards and frameworks for advanced level practice at different paces (Department of Health, 2010; National Leadership and Innovation Agency for Healthcare, 2010; NHS Scotland, 2008; Northern Ireland Practice and Education Council, 2016), with the focus across the nations being on advanced nursing practice until more recently. Whilst there are commonalities across these, such as the use of the same four pillars (clinical, education, research, and leadership), other differences in the educational preparation and strategies for implementing the roles remain evident (Council of Deans of Health, 2018).

Table 1: Historic policy and drivers for advanced level practice in the UK

Date	Title	Author	Summary
1990	Post Registration Education and Practice Project (PREPP)	UKCC	The first standards for post-registration education and practice. Provided an early outline for specialist and advanced practice and included the notion of autonomy.
1992	Scope of Professional Practice	UKCC	This paper provided nurses, midwives and health visitors with the opportunity to increase and develop their practice, with a view that this would enable care to be delivered to patients in a more holistic and seamless manner. Examples of expanded practice included activities traditionally undertaken by medical doctors, such as prescribing, and assessment and diagnostic procedures. Aimed to promote quality care of patients. Required accountability for nurses undertaking expanded practice.
1994 / Updated 2001	Standards for Education and Practice Post Registration	UKCC	Following on Scope, this set out the Council's standards for education and practice following registration. Detailed academic levels for education of the three levels of nursing practice – professional; specialist; advanced.
1997	Council's decision on the setting of standards for advanced practice.	UKCC	Following a listening exercise, the UKCC took the decision to not set standards for advanced practice. They acknowledged that all practitioners have the opportunity of advancing their practice.
1999	Making a difference	Department of Health	Discussed the extension of roles for nursing but leant towards undertaking medical tasks. Introduced the concept of consultant roles for nurses, midwives and health visitors.
2000	NHS Plan	Department of Health	Identified a reformation of the NHS, reducing role boundaries, to allow patients to receive the right care at the right time. The Chief Nursing Officer's '10 key roles for nurses' evolved from this paper – empowering nurses to undertake wider remits. This included promoting advanced and consultant level roles.
2002	Nurse Practitioners: An RCN Guide to the Nurse Practitioner Role, Competencies and Programme Approval	RCN	Original guidance on the nurse practitioner role. Updated in 2008 (see below).
2006	Standards of Proficiency for Nurse and Midwife Prescribers	NMC	Set out the standards and proficiencies for programmes to prepare nurses, midwifes and specialist community public health nurses to prescribe. Provided standards of conduct for registered nurse prescribers.
2006	Modernising Nursing Careers: Setting the Direction	Department of Health	Published by the CNO, this sought to develop nursing and midwifery roles, to ensure a dependable, responsive and fit for purpose workforce. Four key priority areas including updated career pathways /choices, and specifically advanced roles.
2008 (revised /updated 2010, 2012)	Advanced Nurse Practitioners: An RCN Guide to the Advanced Nurse Practitioner Role, Competencies and Programme Accreditation	RCN	Updated in 2008 to reflect NMC proposals to regulate ANP roles, and to reflect the DoH (2006) Modernising Nursing Careers discussions. Aimed to provide guidance to employers, aspiring and current advanced nurse practitioners, and commissioners/ policy makers. It noted a lack of explicit standards and regulation, recommending that the NMC consider these.

2008	Advanced Practice toolkit	NHS Education for Scotland	Developed as a resource for NHS Scotland. Later endorsed by other UK Chief Nursing Officers as relevant to advanced practitioners in their countries.
2008	The National Education and Competence Framework for Advanced Critical Care Practitioners	DoH	Good practice framework which describes the education, skills and competencies of Critical Care Practitioners practicing at the Advanced level. Developed in recognition of wide variations of locally implemented critical care practitioner roles, lack of standardised scope of practice, and inability to quality assure if practitioner sought employment elsewhere.
2009	Advanced Practice: Report to the four UK Health Departments	Council for Regulatory Excellence	Commissioned by the DoH to consider whether separate or additional regulation of advanced practice was necessary. Concluded that "*much of what is often called 'advanced practice' across many of the health professions does not make additional statutory regulation necessary."*
2010	Position Statement on Advanced Level Practice	Department of Health	Following on from the CHRE review, this Position Statement set out to benchmark advanced level practice. It defined the scope of AP and how it differs from the level of practice for nurses at initial registration. It advocated that nurses in AP roles should be educated to master's level, and it provided four themes (precursors to the current pillars), with 28 elements (standards or capabilities). Reinforced importance of ethical practice, responsibility and accountability if practicing at advanced level.
2010	Framework for Advanced Nursing, Midwifery and Allied Health Professional Practice in Wales.	National Leadership and Innovation Agency for Health Care (NLIAH)	Developed to provide guidance to the development, implementation and evaluation of advanced practice roles in NHS Wales. To ensure consistency and governance for roles.
2014	Five Year Forward View	Department of Health	Recognising need to evolve healthcare to meet new challenges. Vision for developing service and new models of care. Need to modernise and develop workforce.
2016	Reshaping the workforce to deliver the care patients need	Nuffield Trust	Identifies advanced practice roles as beneficial to patients, practitioners, and employer. Roles will help to improve continuity of care; provide mentoring / training for less experienced staff; rewarding clinically facing career option.
2016	Advanced Nursing Practice Framework	Northern Ireland Practice and Education Council for Nursing and Midwifery (NIPEC)	Developed to define ANP role. To promote a strategic and consistent approach to the development of the ANP role. Guides employers, educators and nurses.

From 1983, the United Kingdom Central Council (UKCC) become the professional regulator for nurses in the UK, with responsibility for education and training standards, regulation, and disciplinary action for its registrants (Glasper and Carpenter, 2019). Recognising the need to enhance or expand nursing skills and knowledge, the UKCC introduced *The Scope of Professional Practice* (UKCC, 1992). This enabled nurses to adopt new and additional clinical tasks, thereby expanding the nature of their practice within the expectation of individual accountability and personal competence. This work was further developed by the Nursing and Midwifery Council, who replaced the UKCC in 2002, through the development of a framework for post-registration nursing (Nursing and Midwifery Council, 2005) which provided a definition, description and a set of domains of practice, with associated competencies for qualified nurses to be held accountable to.

In the early stages of advanced level practice, two seemingly opposing perspectives of what this meant emerged, that of an extension of nursing roles into the medical domain, or the development of a more expanded and reframed nursing role which focussed on providing a holistic patient focussed level of care (Gray, 2016; Rolfe, 2014). The implementation of the European Working Time Directive (EWTD) in 2004 led to a cap on the hours worked by junior doctors[2] (UK Government, 2003), with the resultant gaps in medical staffing seemingly providing an opportunity for nurses to take on particular tasks and elements of doctors' roles. Whilst this appeared to be an opportunity to advance nursing practice, it also reinforced the positioning of such roles to that of a medical substitution role (Imison et al., 2016; Por, 2008). Conversely, a strong argument endures that advanced level practice should be firmly rooted from the unique paradigm of nursing practice, which supports a focus of 'care' rather than 'cure' (Gray, 2016; Leary and MacLaine, 2019). These tensions in trying to define what advanced practice was is evidenced particularly with the 'maxi-nurse/ mini-doctor' debate that was prevalent at the time (Castledine, 1995; Dean, 2012). This debate demonstrated the challenges in defining where a nurse working at an advanced level was positioned in relation to the paradigms of nursing and medicine. A dichotomy of views regarding the situating of advanced level roles continues to be evidenced (Diamond-Fox and Stone, 2021; Leary and MacLaine, 2019), thus generating continuing examination about how advanced practice roles are defined, positioned and integrated into multi-professional workforce planning and service delivery.

Confusion surrounding the role has been compounded by the discourse relating to the regulation of advanced practice roles, which up until 2023 continued to be viewed as inherent within a nurse's

[2] In September 2024, the term 'junior doctors' was replaced by 'resident doctors'. In this thesis, the old nomenclature is used as this reflects the dialogue of the participants and the wider literature and documentation.

standard registration with the nursing regulatory body (Palmer et al., 2023; York, 2021). Earlier proposals for regulation by the NMC (2005) were not supported by the government at the time, who deemed it unnecessary that advanced level roles should have a distinct additional registration on the NMC register (Council for Healthcare Regulatory Excellence, 2009). Concerns remained that employers or even individual nurses would determine job titles, and the scope and standards for advanced practice roles on a local level, thus contributing to a variation in the preparation and governance of roles (King et al., 2017; Leary et al., 2017).

The CHRE (2009) report did conclude that to promote patient safety and ensure appropriate governance of roles within organisations, a nationally agreed set of standards for advanced level nursing practice was needed. The response to this was the publication of '*Advanced Level Nursing: A Position Statement*' (Department of Health, 2010), which provided a benchmark for defining what 'advanced' was in relation to standards for entry to the nursing register. Additionally, it also set out expectations for practice-based competence, as well as stipulating that educational preparation should be to master's level or equivalent. The Position Statement placed advanced practice as a level of practice, rather than a distinct job role, and set out that this required practice to encompass four aspects of education, research, management, and clinical care, reflecting work done within Scotland previously (NHS Scotland, 2008). However, despite the Position Statement (DH, 2010) providing much needed guidance about advanced level practice, the issue of a lack of distinct regulation for nurses working in advanced level roles remains in contrast with other disciplines, notably medicine, which holds separate registers for doctors who have completed specialist medical qualifications such as General Practitioner (GP) training (General Medical Council, 2024).

Healthcare policy during this period, such as the NHS England *Five Year Forward View* (NHS England, 2014), and the subsequent *Next Steps on the NHS Five Year Forward View* (NHS England, 2017) identified the need for transforming health and social care services, with a necessity to develop the healthcare workforce to enable the changing demand to be met. These and other key policy drivers set out plans to ensure the needs of patients with chronic health conditions and patients with more complex health problems are being met, alongside a drive to address health inequalities and to promote better health of the population. As such, advanced practice nursing roles in the UK continued to be developed and implemented across a range of clinical areas including primary care, acute (secondary) care and within specialist areas such as offender health and hospice care (Lawler et al., 2020). However, without clear standardisation of education and role preparation requirements, there remained a lack of consistency in how roles were implemented, often without support or governance from the wider organisation.

Consequently, nurses were vulnerable to challenges about their advancing role and their legitimacy to practice (Barton and Allan, 2015).

The current landscape of advanced level practice

The Department of Health Position Statement (2010) remained the seminal published standard for advanced level practice in England until the emergence of the '*Multi-professional framework for Advanced Clinical Practice in England*' framework (MPF) (Health Education England, 2017). Since its publication, work continues to develop advanced level practice, led by the Centre for Advancing Practice, which was established by Health Education England (now NHS England). A number of further policies, guidelines, frameworks and professional body standards have emerged, which continue to influence the development and enactment of advanced level practice in the UK (See Table 2 – Contemporary policy and drivers for advanced level practice in the UK).

Table 2: Contemporary policy and drivers for advanced level practice in the UK

Date	Title	Author	Summary
2017	Multi-professional framework for advanced clinical practice in England	Health Education England	Follows on from 'Reshaping the workforce.' Offers an agreed definition of the ACP role that encompasses different professional groups. Sets out standards for working at advanced level; outlines capabilities expected of practitioners working in an advanced role. Provides guidance for educational preparation, support, and employer governance.
2018	RCN Standards for advanced level nursing practice.	RCN	The most recent iteration of earlier publications of standards (first mapped out in the early 2000's). The standards set out to define advanced level nursing practice, as well as set out guidance for the skills, knowledge and the educational preparation for nurses working in advanced roles.
2019	NHS Long Term Plan	NHS England	Strategic plan to ensure NHS is fit to meet changing demands. Wide ranging plan – includes looking at new ways of delivering services, and recognition/ credentialling of advanced roles. Innovation to address recruitment and retention; improve care standards.
2020	NHS People Plan 2020/21	NHS England	NHS workforce strategy plan to support the NHS Long Term Plan. Sets out how retention, support, and belonging will be improved. Discusses new ways of working, and roles such as AP/ ACP roles for growing the future workforce.
2020	Multi-professional consultant-level practice capability and impact framework.	NHS England / Centre for Advancing Practice	Provides clarity for practitioners and employers regarding the development and implementation of consultant level roles. Identifies domains and capabilities expected.
2020	Launch of Programme Accreditation process	Health Education England	Accreditation of HEIs whose programmes have been successfully mapped against the 'Multi-professional framework for advanced clinical practice in England' and the 'Standards for Education and Training.' This provides a benchmarked route for graduating practitioners and their employers
2021	Launch of the ePortfolio (supported route)	Health Education England	To allow existing advanced practice role holders to gain recognition for previous educational qualifications and experience which was gained outside of completing an Accredited MSc course. Allows individuals to show a level of knowledge, skills and practice that is equivalent to contemporary standards and capabilities.
2022	Emergency Medicine Advanced Clinical Practitioner Curriculum	Royal College of Emergency Medicine	Updated curriculum (previous one 2017), to set out standards and evidence required for ACPs in emergency medicine settings who wish to apply for credential status with the college.
2023	Professional framework for enhanced, advanced and consultant clinical practice in Wales	Health Education and Improvement Wales	Draws upon previous NLIAH (2010) Framework, as well as work from the other UK nations. Framework addresses three levels of practice. Aligned to Skills for Health (2020) Career Framework. Provides clarity, guidance and principles for practitioners, employers and educators to support the governance and standards of practice.

2024	Professional development framework – levels of nursing. Consultant Level Nursing	RCN	Definition, standards and capabilities for consultant level of nursing. To provide clarity for nurses, employers and HEIs.
2025	Principles for advanced practice	NMC	Following an independent review ((Palmer et al., 2023), the NMC concluded a need to develop additional regulation of advanced level nursing practice. This will include the development of standards of proficiency, and standards for educational programmes.
2025	Multi-professional framework for advanced practice in England	NHS England	A refreshed update of the 2017 MPF. This version incorporates updates which reflect the changing landscape of advanced level practice. Changes language from 'advanced clinical practice/ practitioner' to 'advanced practice/ practitioner.' It has a stronger emphasis on equality, diversity, and cultural competence. Aims to align with the evolving demands of modern healthcare.
2025	Fit for the future: the 10 year health plan for England	NHS England	Promotes three key radical shifts to improve population health and healthcare delivery, including shift from hospital focussed care to community. Recognises need for advanced practice workforce models.

Whilst the multi-professional framework is specific to England, it extended the vision already set out within their own distinct frameworks by the other devolved UK countries of Wales, Scotland, and Northern Ireland (National Leadership and Innovation Agency for Healthcare, 2010; NHS Scotland, 2008; Northern Ireland Practice and Education Council, 2016). The framework provided an explicit definition and clearly set out that it was positioning advanced practice as a level of practice rather than a role or job title:

> *"Advanced clinical practice is delivered by experienced, registered health and care practitioners. It is a level of practice characterised by a high degree of autonomy and complex decision making. This is underpinned by a master's level award or equivalent that encompasses the four pillars of clinical practice, leadership and management, education and research, with demonstration of core capabilities and area specific clinical competence. Advanced clinical practice embodies the ability to manage clinical care in partnership with individuals, families and carers. It includes the analysis and synthesis of complex problems across a range of settings, enabling innovative solutions to enhance people's experience and improve outcomes" (Health Education England, 2017: 8)*

The HEE framework and its definition signifies a move away from the nursing focussed strategies that had previously prevailed, instead recognising that advanced level practice was also being evidenced by other regulated non-medical professional groups, such as physiotherapy (Chartered Society of Physiotherapy, 2011), paramedics (College of Paramedics, 2015), and pharmacists (Royal Pharmaceutical Society, 2013). This shift is inherent in the use of the term 'advanced clinical practice' within the framework, which appears to deliberately avoid association to any particular professional group, for example advanced nursing practice. The Royal College of Emergency Medicine had already initiated a training and competency curriculum in 2015 for Advanced Clinical Practitioner roles within that speciality, potentially contributing to the ambiguity of where advanced '*clinical*' practice roles are positioned in relation to their scope and paradigm of practice (Lawler et al., 2020; Leary and MacLaine, 2019). Critically, with many newer roles across a range of specialities being labelled as 'advanced clinical practitioner' (ACP) roles, it is suggested that this title has become synonymous with an omniprofessional role for which the original professional identity and unique body of professional knowledge has little or no relevance for employers (Lawler et al., 2020).

The emphasis that advanced practitioners should demonstrate the capabilities set out across all of the four pillars which are within the multi-professional framework reflects work done previously (Department of Health, 2010; NHS Scotland, 2008). However, evidence suggests that the clinical pillar pervades as the most dominant one in practice for many advanced practitioners and employers (Hooks and Walker, 2020; Lawler et al., 2020). Reasons for this are often attributed to high clinical

workloads and the demand that working time is to be used in direct practice settings (Fothergill et al., 2022). It has also been shown that a lack of organisational planning for advanced practice roles can lead to a lack of protected time for non-clinical activities (Dean, 2023c; Drennan et al., 2022).

The majority of published research relating to advanced level practice focuses on elements relating to the clinical pillar, often evaluating and comparing the advanced clinical skills to those of medical professionals (Collins, 2019; Denton et al., 2021; Evans et al., 2021; Laurant et al., 2018). It can be argued that this promotes the narrative about the equivalence of advanced practice roles, which in turn reinforces the persisting discourse that advanced level roles are inherently a solution to a shortfall within medical staffing rather than an advancement of the professional status of that group, such as nursing. A growing body of research is emerging, and whilst much of this is small scale (for example, based on one service / organisation), evidence including several systematic reviews, support a range of positive outcomes with advanced practice roles, including impact on patient well-being and quality of care, as well as benefits for healthcare employers and providers of care particularly around improving service delivery (Evans et al., 2021; Laurant et al., 2018; Mann et al., 2023; Woo et al., 2024).

In some specialities, the dominance of medicine appears evident through the provision of distinct competency frameworks for advanced practice roles held by nurses, such as those provided by the Royal College of Emergency Medicine (Royal College of Emergency Practitioners, 2022) for Advanced Clinical Practitioners, and the Faculty of Intensive Care Medicine (Faculty of Intensive Care Medicine, 2023) for Advanced Critical Care Practitioners. Both of these recognise and acknowledge the importance of the advanced practice capabilities set out in the multi-professional framework (Health Education England, 2017). These capabilities reflect the knowledge, skills and behaviours (KSBs) expected from any professional working at an advanced level, underpinned by higher level critical thinking and professional judgement, but they stop short of stipulating explicit clinical skills or role competencies. This approach reflects the wide scope and context of advanced practice roles implemented across many different fields of practice (Drennan et al., 2022; Evans et al., 2021; Lawler et al., 2020), which prevents a 'one size fits all' approach.

The scale and pace of the implementation of advanced practice roles continued to fuel the ongoing debate around regulation for advanced level roles (King et al., 2017; York, 2021). Recognising the changing context of care, concerns about governance processes, and lack of consistency of training and practice standards for advanced roles, which could impact on public trust and safety, the NMC commissioned an independent review by The Nuffield Trust to explore this further (Palmer et al., 2023). Following a review of this evidence, and considering public and professional feedback, the NMC have recently moved forward to develop and implement a range of standards and regulatory

measures for registrants working in advanced roles (Nursing and Midwifery Council, 2024a; 2025). Whilst this may be welcomed by some professionals and stakeholders, it raises potential questions about how this will work in reality. An example of this is particularly unclear where nurses and AHPs may be in the same job role and the same team, for example as an ACCP, but may have differing standards to meet for their individual regulatory bodies.

The exact impact of the NMC regulatory position and subsequent application of professional standards for advanced level nursing practice is not yet clear. Palmer et al. (2023) argues that regulation of advanced level practice could provide a higher level of prominence, visibility and clarity of such roles. This could potentially enhance the individual practitioner's professional identity, positionality and legitimacy to practice within the wider healthcare team. Existing frameworks, such as the '*Multi-professional framework*' (Health Education England, 2017; NHS England, 2025b), and relevant medical body frameworks, for example FICM's ACCP framework (Faculty of Intensive Care Medicine, 2023), are already in place which may require the individual practitioner to provide additional evidence to practice. Whilst these frameworks do have some alignment, adding additional parameters set by the nursing regulatory body may cause further challenges or complexity, and may even be unwelcomed by some advanced practitioners. A recent study suggested that the creation of a new 'profession' solely for ACPs would be welcome by some practitioners in advanced level roles, indicating that they would be happy to leave their original profession (Timmins et al., 2023). In contrast, Mackavey et al. (2024) implies that without the ability to quantify the value added from the original professional status, such as nursing, to an advanced practice role, the position and professional identity of the advanced practitioner is detrimentally affected and weakened.

The impact on professional identity when new roles are commenced is well documented across a range of environments and practitioner roles, for example student nurses to qualified practitioners (Draper, 2018; Whitehead et al., 2016) and clinicians to educator roles (Harper-McDonald and Taylor, 2020; Logan et al., 2016). For new roles, identity may shift as the emergence and impact of new roles becomes evident. However where there is a lack of existing role models for more novel or unique roles such as the Advanced Critical Care Practitioner role, the socialisation process and subsequent embedding of a clear professional identity may be inhibited (Cornett et al., 2023). The next section will provide context relating to the clinical speciality of critical care, followed by consideration of the nursing role within this environment, before focusing on advanced level nursing practice roles.

The nature of critical care in the UK

The evolution and provision of care for critically ill patients

This research is concerned with experiences situated within the field of critical care, requiring an appreciation of this relatively recent speciality within the wider field of medicine and healthcare. Critical care is an umbrella term which encompasses the provision of care for patients with serious life-threatening illnesses. Also referred to as intensive care, it is a service in hospitals which provides specialist observation and care for patients who are acutely or critically ill, which cannot be delivered safely in a general ward or department (Faculty of Intensive Care Medicine, 2022b). Both the terms 'critical care' and 'intensive care' will be used accordingly, to reflect the variance in nomenclature used by professional organisations and published literature.

The evolution of close monitoring and observation of a more seriously ill or injured patient can be attributed to the work pioneered by Florence Nightingale during the Crimean War (1853-1856), who advocated that these patients were moved to the area closer to the nurses station to facilitate observation (Kerlin et al., 2021). The building of a purposely designed intensive care unit, Mead Ward, in St. Thomas' hospital in London is generally recognised as the first of its kind in the UK. Since then care for the critically ill patient in the UK has continued to be delivered in distinct geographical areas within the acute hospital settings, typically High Dependency Units (HDU), Intensive Care or Intensive Therapy Units (ICU or ITUs) or Critical Care Units (CCUs) (Reynolds and Tansey, 2011). However the provision of intensive care varied within and between hospital Trusts, and in 1999, an Expert Group review found a lack of consistency in the organisation and management of intensive care, wide variations in standards of care, disparity in resourcing including human resources, and concerns regarding the availability of intensive care to meet the demand in some organisations (Audit Commission, 1999). The report led to the publication of a new national framework, '*Comprehensive Critical Care: A review of adult critical care services*' (Department of Health, 2000a) which set out proposals to improve standards of organisation of critical care within and between NHS Trusts. Comprehensive Critical Care identified the workforce development needs to ensure appropriate and safe staffing, and stipulated the need to initiate and develop improved evidence-based standards and guidance underpinned by an enhanced data collecting culture (DOH, 2000a). Of significance at the time, the focus of delivering critical care only to those patients who were physically located in ICUs shifted to the provision of critical care services across the wider hospital environment. The application of a classification of critical care patients was introduced to show need for critical care expertise irrespective of the patient's actual location (DOH, 2000a)(see Table 3).

Table 3: Levels of Critical Care

Levels of Critical Care ((Department of Health, 2000a; Intensive Care Society, 2009)	
Level 0	Patients whose needs can be met through normal ward care in an acute hospital.
Level 1	Patients at risk of their condition deteriorating, or those recently relocated from higher levels of care, whose needs can be met on an acute ward with additional advice and support from the critical care team.
Level 2	Patients requiring more detailed observation or intervention including support for a single failing organs system or post-operative care or those 'stepping down' from Level 3 care.
Level 3	Patients requiring advanced respiratory support alone, or basic respiratory support together with support of at least two organ systems. This level includes all complex patients requiring support for multi-organ failure.

The classification of levels of care continued to be reviewed and applied within the Guidelines for the Provision of Intensive Care Services (Intensive Care Society, 2019) until it was formally updated in 2021 (Intensive Care Society, 2021). The continuing and increasing demand for the provision of critical care has been driven by multi-factorial considerations, with technological, pharmacological, and medical advances providing the opportunity to undertake more complex surgeries and treat patients with a wider range of underlying pathologies (Faculty of Intensive Care Medicine, 2021a). In March 2025, there were approximately 4000 adult critical care beds provided, within around 130 acute NHS Trusts in England (NHS England, 2025d), with a number of Trusts having more than one critical care unit. The number of actual critical care beds available each day fluctuates slightly due to the flexible provision of Level 2 or Level 3 care, and in response to the availability of nursing staff to care for the patients. Annual data for 2023-24 shows there was over 236,000 critical care records (admissions) in that year, with a majority of patients being admitted as an unplanned event, typically from elsewhere within the same NHS Trust, such as general wards, operating theatres or the Accident and Emergency Department (NHS Digital, 2024).

An effective critical care service provides care for a spectrum of patients with differing clinical needs, and so requires a specialist and multi-disciplinary team approach (Carter and Notter, 2020). Patients admitted to a critical care unit remain assigned to a named medical Consultant who provides the specialist medical care for the originating cause of the patient's acute ill health (for example, a Consultant surgeon, or Consultant physician). The day to day operational and clinical management of patients in critical care are co-ordinated by a named critical care Consultant who is trained in intensive care medicine (ICM) (Faculty of Intensive Care Medicine, 2021a). The complexity of critical illness and critical care requires a multi-professional team approach, typically consisting of a mix of medical,

nursing, and allied health professionals (for example, physiotherapists, pharmacists, dieticians, speech and language therapist). Each professional group contributes their unique and specialist knowledge, skills and behaviours which are integral for the care for a critically ill patient (Intensive Care Society, 2022). Within this context, critical care staff work closely and collaboratively to achieve high quality and safe care, and as such it is suggested that there is a flattened traditional hierarchical structure typically associated with other healthcare teams (Ervin et al., 2018; Xyrichis et al., 2017). In particular, critical care nurses and doctors have been shown to interact in ways which suggest a more flexible and blurred model of decision-making and asserting influence at times (Xyrichis and Rose, 2024). Other factors are important to note which can affect the positioning and relationships between critical care nurses and doctors. This includes the nature of the shift patterns, the number of nursing staff required for the dependency of the ill patients, and rotation of staff between different critical care areas. This can result in a low temporal stability of the team, in essence meaning the composition and interactions of the team can vary from day to day (Ervin et al., 2018).

Critical care nurses / nursing

The largest professional group within the multi-professional team in critical care units are nurses. Nursing care for a critically ill patient is complex and challenging and usually involves a continuous presence at the patient's bedside allowing close monitoring and a rapidly responsive delivery of care to the patient (Adam et al., 2017; Credland and Gerber, 2021). For Level 3 patients, this care should be delivered on a 1:1 patient to nurse ratio (Intensive Care Society, 2019). The critical care nursing role is considered to be highly technical, with many patients requiring mechanical ventilation, renal replacement therapy, and invasive haemodynamic monitoring. Experienced critical care nurses are required to interpret and respond to blood tests, to titrate multiple intravenous infusions including sedation and inotropes in response to changing physiological parameters, and make adjustments to settings on a range of specialist equipment used to support organ dysfunction (Adam et al., 2017). A technical, biomedical aspect of the role is essential, but that may be viewed as being in opposition to a more holistic or patient centred approach typically associated with the practice of nursing (Crilly et al., 2019). This notion is refuted, as the non-technical elements of nursing care, such as the provision of personal care, psychosocial support and care of the patients family during a period of critical illness remain a core requisite of the role (Credland and Gerber, 2021).

Role preparation and professional development

Nurses entering the speciality of critical care require further development of specialist skills and knowledge that is particular for this field of nursing practice (Critical Care National Network Nurse

Leads Forum (CC3N), 2023; Intensive Care Society, 2022), and which is beyond the standards of proficiency gained at the point of professional registration as a nurse (Nursing and Midwifery Council, 2018a). The first formally accredited and structured course was developed in 1972, and approved by the Joint Board of Clinical and Nursing Studies (JBCNS), which comprised of members of both medical and nursing Royal Colleges, and members of the Department of Health (Gordon and Sherwood Jones, 1998). This course ran until the abolishment of the JBCNS in 1983, which was replaced by the United Kingdom Central Council for Nursing, Midwifery and Health Visiting (UKCC), and the formation of four National Boards, which included the English National Board (ENB). Renamed as the 'ENB 100 General Intensive Care Nursing' Course', this post-registration course provided nurses and employers with evidence of a specialist qualification, and was viewed as essential to gain a promotion within the speciality (Wigens and Westwood, 2000). However, concerns about the diversity of content, assessment and standards of practice were emerging, and this raised questions about the transferability and comparability of nurses with this qualification across the nation (Endacott et al., 2000). From 2002, when the ENB was abolished, critical care education continued to be provided by HEIs to varying standards, although many aimed to maintain the scope set out previously. In 2012, the first national Critical Care Nurse Competency Framework was launched (Critical Care National Network Nurse Leads Forum (CC3N), 2023). This framework consists of four levels (referred to as Steps) to facilitate development and progression in a safe and structured manner, as set out in Table 4:

Table 4: Overview of National Competency Framework for Adult Critical Care

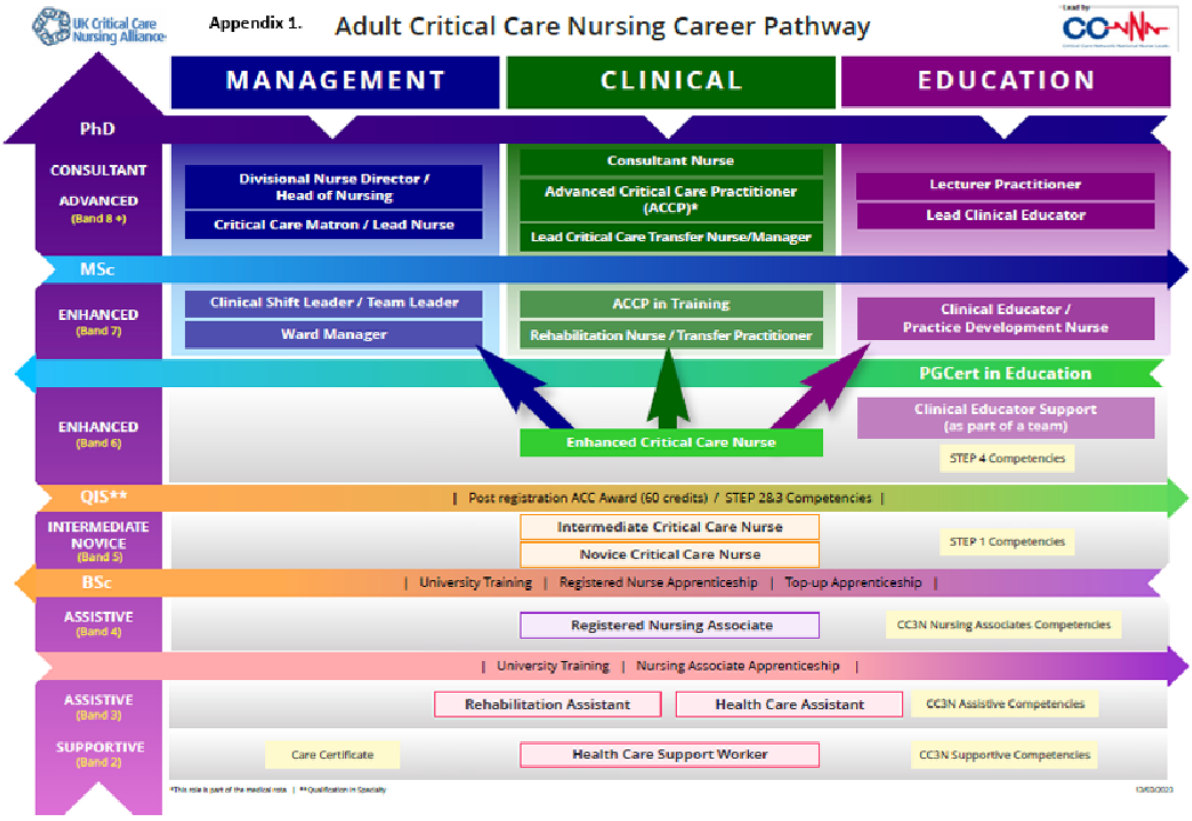
Step level	Career stage	
Step 1 Competencies	For nurses new to critical care. Undertaken during preceptorship programme or similar (within first 12 months in speciality)	Provides core skills, with fundamental underpinning knowledge.
Step 2 Competencies	During a formal academic critical care programme. Step 1 must be completed prior to this.	Deeper theory and knowledge of core curriculum. Increase in variation and complexity of critical care nursing practice.
Step 3 Competencies	During a formal academic critical care programme.	Develops skills in leadership, supervision of others, and other higher-level problem solving and analytical skills.
Step 4 Competencies	Following formal academic critical care programmed, and completion of the previous Steps.	Additional Step added in 2018. Focus is on leadership and management within critical care services.

Adapted from: CC3N (2023) National Standards for Adult Critical Care Nurse Education

The provision that Steps 2 and 3 competencies are completed as part of a formal academic critical care programme has led to many HEIs embedding these as part of their curriculum, and provides the nurse with a degree or Masters level qualifications (Deacon et al., 2017). Importantly, completion of such courses is essential to meet the standard that a minimum of 50% of registered critical care nurses are to have a post-registration award (Critical Care National Network Nurse Leads Forum (CC3N), 2023; Intensive Care Society, 2022). However, the last significant UK survey (excluding Scotland and parts of Wales) found an average of 48.8% of nurses had achieved this, although there was significant variance across critical care units (Cutler et al., 2021). The report also suggested that coupled with expected staff turnover and retirement, this could imply a more 'novice' level of critical care nursing workforce which is relatively inexperienced and lacking higher level clinical and academic skills.

All NHS nursing roles are aligned to the NHS Agenda for Change banding, and nursing posts within critical care include all bands from 5 to 8, with the majority of registered nurses employed within critical care being in staff nurse Band 5 roles (Cutler et al., 2021). The number of nurses within each band reduces significantly, with Band 7 to 9 roles typically being those of educators, clinical leads/ Matron, Advanced Critical Care Practitioners, or Nurse Consultant posts (Horsfield, 2020). The United Kingdom Critical Care Nursing Alliance (UKCCNA, 2024), a collaboration of six UK critical care organisations, developed the '*Critical Care Nursing Workforce Optimisation Plan and Staffing Standards 2024-2027*', a framework to map out and support a stable and sustainable nursing workforce. The framework reflects the current standards for nurse staffing, as well as providing other guidance for critical care leaders regarding supporting staff development and career progression (see Figure 1).

Figure 1: Extended Adult Critical Care Nursing Career Pathway (UKCCNA, 2024)



The framework explicitly acknowledges advanced level practice as part of the spectrum within critical care nursing, including Advanced Critical Care Practitioners, and the next section will consider how advanced nursing roles have been enacted in this speciality.

Advanced level practice in critical care

Advanced level nursing practice roles within UK critical care settings have emerged with varying titles but have typically reflected core roles such as Consultant Nurse's (CN's) and Critical Care Outreach (CCO) practitioners, and more recently Advanced Critical Care Practitioners (ACCPs).

Critical Care Outreach

The publication of '*Comprehensive Critical Care: A review of adult critical care services*' (Department of Health, 2000a) introduced the concept of 'critical care without walls', recommending the development of Critical Care Outreach teams. In acute Trusts, CCO teams form part of a wider strategic approach to the recognition and prevention of deterioration in patients across the hospital, although other teams such as Patient at Risk teams, Hospital at Night teams, and Medical Emergency Teams are often also operated (Hyde-Wyatt and Garside, 2020). A key difference for CCO teams is the requirement that they monitor and support patients discharged from critical care to expediate their recovery. A significant part of this remit is the ongoing support and education of ward-based staff to

ensure they are equipped to recognise and intervene if a patient's condition is of concern (Intensive Care Society, 2022). Despite CCO being introduced more than 20 years ago, variation in the preparation and practice standards for the roles has existed, prompting the development of nationally agreed standards of skills, competencies and behaviours for CCO practitioners (Intensive Care Society /National Outreach Forum/ Critical Care Networks - National Nurse Leads, 2022). The skills, knowledge and behaviours reflect the four pillars of advanced practice, therefore setting out requirements relating to each of these. The framework positions CCO as a spectrum of practice, from enhanced practice but with recognition that advanced, or consultant level Outreach practice could be attained.

Consultant Nurses

Consultant nurse roles emerged in 1999 with the expectation that this would strengthen and enhance nursing leadership and contribute to the modernisation agenda of the NHS at the time (Department of Health, 1999; 2000b). Manley's (1997) seminal action research study led to the formation of a conceptual framework for advanced practice and consultant nurse roles, advocating that the intent of advanced level practice was improved quality of patient care, and that this was achieved through the development and promotion of nursing practice. The proposed consultant nurse role would be framed within four core functions – *expert practice; professional leadership and consultancy; education and development; practice and service development linked to research and evaluation* – functions which originated from American Nurse Practitioner sub-roles (Hamric and Spross, 1989), and which reflect the current four pillars of advanced practice (Health Education England, 2017; NHS England, 2025b). Manley (1997) clearly positioned advanced practice as being developed from an existing base of professional and expert 'know-how' and 'know-that' nursing practice, although consideration of professional identity or professional boundaries was not explicitly discussed in her study. More recently, Professor Manley has led work to further establish multiprofessional consultant roles as essential for modern workforce development, and for meeting the strategic priorities of contemporary healthcare providers (Manley et al., 2022).

The *'Multi-professional consultant-level practice capability and impact framework'* (Health Education England, 2020) was published to provide clarity for practitioners moving beyond advanced level practice, and has been since updated to reflect transitional stages from advanced into established consultant practice (Centre for Advancing Practice, 2023). Complementing the multi-professional approach for advanced level practice (Health Education England, 2017; NHS England, 2025b), the consultant framework recognises domains of knowledge which are applicable across all professional consultant level roles. However, it clearly recognises the value and expectations of demonstrable

credibility and expertise in the practitioners own particular professional field of practice (Crouch et al., 2024). The establishment of consultant nurse roles in critical care has been shown within early work by Fairley (2003; 2005), Coombs and Chaboyer (2007), and Dawson and Coombs (2008), amongst others, but contemporary published literature of how the role is enacted more recently, or its impact on care provision, is lacking. Nonetheless, it remains relevant to critical care nursing as evidenced within the recent Adult Critical Care Nursing Career Pathway framework (UK Critical Care Nursing Alliance, 2024).

Advanced Critical Care Practitioners

More recently some critical care services have sought to counter the challenges faced in relation to an anticipated worsening of medical staffing for Critical Care units through a newer, distinct role of Advanced Critical Care Practitioners (ACCP's). The key remit of the ACCP role is to support the critical care medical workforce in the assessment, diagnosis and management of the critically ill patient (Denton et al., 2023; Intensive Care Society, 2022). The emergence of the role has been attributed to a range of factors, such as the implementation of the European Working Time Directive (EWTD) which led to difficulties in maintaining medical staffing in critical care units (Boulanger, 2008). Recognising the need to provide a stable and consistent expert workforce for critical care (Faculty of Intensive Care Medicine, 2021a) through new ways of working, the Critical Care Practitioner programme was piloted from 2004 within seven NHS Trusts. Findings from these pilot sites informed the development and publication in 2008 of the 'National Education and Competence Framework for Advanced Critical Care Practitioners' (Department of Health, 2008). The framework defined the role of the ACCP, with reference to the scope and limitations of their clinical practice, and was further supported with the publication of the first Curriculum for Training for ACCPs in 2015, recently updated in 2023 (Faculty of Intensive Care Medicine, 2023). The framework and curriculum standards clearly set out the process for the education and assessment of trainees to ensure a standardised and nationally recognised level of skills and knowledge. This is achieved through a distinct competency-based master's level course at an approved Higher Education Institution alongside a fully supported trainee clinical role, which must be within an approved Intensive Care Medicine training healthcare organisation. Once training has been completed, ACCPs can apply for ACCP membership with FICM which provides them with access to continuing professional development and career resources, whilst confirming recognition of the quality of their training and qualification (Faculty of Intensive Care Medicine, 2023).

An early criticism of emerging advanced roles in critical care was that professional boundaries become blurred and less clear, presenting a challenge as to the image and identity of nurses (Albarran and

Scholes, 2005). This argument was challenged by Carole Boulanger, a Nurse Consultant and ACCP working in one of the pilot sites involved in the development of the ACCP role. Boulanger (2008) strongly advocates that nurses moving into the ACCP role allows for an enhanced continuity of expert care to be delivered to the critically ill patient, something that the rotation of junior and training doctors did not allow for. Cutler et al. (2021) suggest that the role also provides a distinct career structure which allowed the senior nurse to remain clinically focussed rather than moving into a management or teaching role. However, concerns about the role include its contribution to an increasing loss of senior nursing leadership and expertise (Horsfield, 2020), although it is argued that they remain within the clinical environment and can actively contribute to the day by day support and education of critical care nurses (Lee et al., 2018). Another recurring concern directed at advanced level roles in general is the perceived negative impact of the role on the training and support provided for junior doctors, and this is also noted within the critical care speciality (Lee et al., 2018). However, this view is being challenged by advanced practitioners who themselves provide supervision and training for junior doctors (Denton et al., 2021; Williams et al., 2019).

Professional positioning of the ACCP

As shown in the UKCCNA Nursing Career Framework (Figure 1), the ACCP role is positioned as a career option within the critical care nursing framework. However, it is recommended that management and role accountability lies within both a medical and nursing domain (Intensive Care Society, 2022). Whilst AHPs can apply for a trainee ACCP role, most of those recruited are from the nursing profession (Denton et al., 2023; Horsfield, 2020). The FICM curriculum, post qualifying FICM ACCP membership, and ACCP appraisal and career development process all indicate a controlled and medicalised role (Faculty of Intensive Care Medicine, 2023). Despite this, nurses in ACCP roles remain registered with the NMC, and must adhere to their professional Code and other relevant standards. There had been consideration to have the ACCP role regulated as one of four 'Medical Associate Professions' (along with physician associates (PAs), anaesthesia associates (AAs) and surgical care practitioners (SCPs)). This would clearly place these roles in the medical domain irrespective of the base profession of the person undertaking them (if applicable, as the PA and AA roles do not require a registered healthcare professional to undertake them) (Department of Health and Social Care, 2017). The NMC's (2017) stance at the time was that nurses undertaking advanced practice roles which may be subject to separate statutory regulation in the future (such as the ACCP role) may be required to relinquish their NMC registration. This stance would have significant ramifications for the post holder, including loss of the rights to practice as a nurse in the future and loss of professional identity. Subsequently in 2021, a poll of ACCPs resulted in 77% of respondents indicating that alignment to the MAP agenda for regulation was not supported, leading to a formal move towards aligning the role with the Centre for

Advancing Practice and the multi-professional framework (Faculty of Intensive Care Medicine, 2022a). Consequently, notwithstanding the recent NMC regulatory decision for advanced nursing practice roles, nurses in ACCP roles will be expected to work and adhere to the FICM standards but also ensure they meet the professional standards required for revalidation (Nursing and Midwifery Council, 2024b).

Chapter summary

Nursing has evolved from an unskilled, subservient occupation to a profession which is multi-faceted and evolving. In particular, advanced practice roles have been driven by different professional and policy related factors over several decades. The national advanced practice workforce agenda continues to move forward, led by NHS England's Centre for Advancing Practice. This is evidenced by a range of key priorities concerned with ensuring standards for advanced practice education, with the provision of guidance for training, supervision and workforce governance (NHS England Centre for Advancing Practice, 2024). Nonetheless, differing views pervade on what advanced level roles are, how roles are deployed within services and organisations, and how the role holders experience the transition into a new role. Within the speciality of critical care, the development and career progression of nurses is supported by established frameworks. This includes advanced practice roles, particularly the ACCP role which is the predominant advanced practice role in the speciality.

Recognising the current challenges within nursing and more widely the UK healthcare system, this research is particularly relevant in the context of how critical care nurses undergo the transition into an ACCP role, to understand their personal experiences. Chapter 3 will therefore present a scoping literature review to explore in more detail the concepts relating to the transition into advanced practice roles, and the experience of nurses who undertake this transition. This review will support the need for this current study by illustrating the gaps in the field of interest, specifically critical care nursing.

Chapter 3 Literature review

Introduction

This chapter will present an overview of the literature and theoretical concepts relating to the transition of nurses moving into advanced practice roles, and how this may affect nurses' professional role identity and positionality within the wider healthcare team. Within IPA studies, literature and theoretical models are not key in guiding the research process towards any particular theory or hypothesis (Smith et al., 2022). However, exploration and engagement with the evidence and other literature helps to situate the research in context with what is known in the field of interest.

In this chapter, I have utilised a scoping review methodology to identify and consider relevant literature on these phenomena of interest. The rationale for selecting a scoping review approach, and the process undertaken for conducting the search will be outlined before the literature review findings are presented. The narrative analysis of the literature will consider the process of transition into an advanced practice role, professional identity in relation to advanced nursing practice roles, positionality, and advanced practice nurses' relationships with the wider team. Within the scoping review, I have taken a 'light touch' exploration of key theories and concepts relating to the identified themes, namely transition, professional identity and positioning of professional roles within professional teams will be provided. The chapter concludes with the identification of gaps in the wider literature. This will support the justification for this study and inform the research methodology and design.

Rationale for undertaking a scoping review

A scoping review of the literature was chosen to explore the range of heterogeneous evidence relating to the experience of nurses transitioning into advanced practice roles. Traditionally, literature reviews are undertaken at an early stage of a research study to demonstrate a clear understanding of the existing literature, and to establish gaps in the empirical evidence, justifying the research project (Aveyard, 2023). However, it was important to consider the philosophical stance of Interpretative Phenomenological Analysis which is the chosen methodological framework guiding the research study. This required an open minded approach to the collection and analysis of participant data, and so any pre-conceptions, from either my own experience or from the body of literature, need to be managed and reflected upon (Smith et al., 2022).

Scoping reviews differ from other types of literature review such as a systematic review, which aims to synthesise evidence through a structured and transparent approach to discover evidence-based

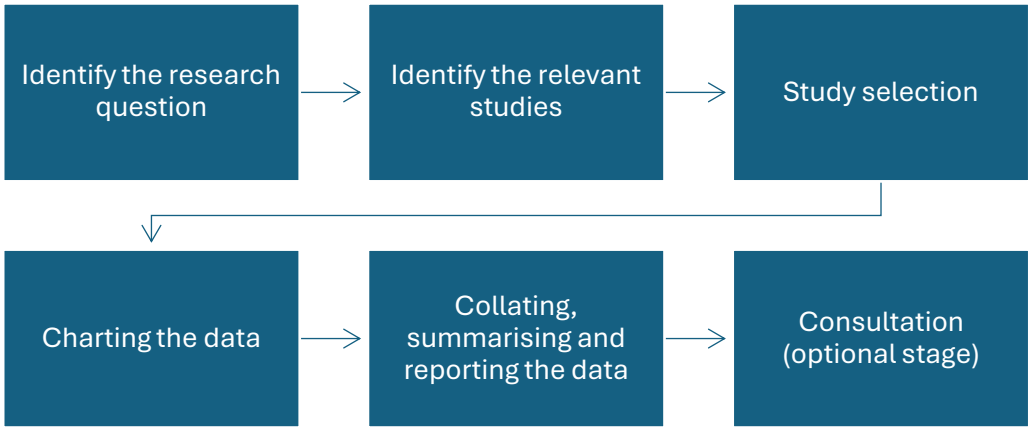
answers to a distinct research question (Boland et al, 2017). It was not the aim of this review to provide an empirical answer to a pre-determined question, and so it was not appropriate to undertake a systematic review. In contrast, a scoping review methodology allowed for definition and clarification of the key concepts and examination of existing debates in the wider field, drawn from a range of evidence (Arksey and O'Malley, 2005; Munn et al., 2018). This enabled me to take an exploratory approach which facilitated a narrative account of the evidence, whilst maintaining an open and reflexive stance which is essential for this study.

An enduring criticism of scoping reviews is they do not specifically require the consideration of the quality of the evidence being included, which may then draw into question how such a review can be applied to practice or policy change (Peterson et al., 2017) . This can also lead to suggestions that it is a less rigorous form of review (Pham et al., 2014). However, one of the first published methodological frameworks for scoping reviews (Arksey and O'Malley, 2005), clearly stipulates that the quality of evidence should not limit the appraisal and inclusion of evidence into the review. Although this stance has been challenged more recently (Daudt et al., 2013), the current standard 'The Preferred Reporting Items for Systematic reviews and Meta-Analyses extension for Scoping Reviews' (PRISMA-ScR) checklist stipulates that critical appraisal of each individual source of evidence in a scoping review is optional, reinforcing the focus of scoping reviews as providing an overview of evidence (Tricco et al., 2018). Therefore, formal assessment of the methodological quality of the included studies in this review was not undertaken, but a 'light touch' consideration of potential strengths and limitations of the studies was applied to promote some criticality. It is important to note that this scoping review does not claim to have exhausted every source of information about the key concepts relating to nurse role transition and the impact of moving into an advanced practice role but instead provides an iterative process to develop familiarity with the literature.

Scoping review framework

To provide a structure and to aid transparency of the scoping review process, Arksey and O'Malley's (2005) original six stage framework for the conduction of scoping reviews was adopted (See Figure 2).

Figure 2: Scoping review framework (Arksey and O'Malley, 2005)



The key stages of a scoping review are not dissimilar to other types of literature reviews, as they require a distinct topic of interest, a defined research question or aim, and should provide detail of the process of searching for relevant literature and extracting key data (Khalil et al., 2016; Peterson et al., 2017). An initial search of the literature was completed in 2019/20 which supported the production of my research proposal and the initial stages of developing the research study. However, as I continued to develop the research question, research aims, and the methodology, I determined that re-running the literature search and incorporating some slight changes to the keywords and search strategy would be beneficial. Therefore, a more formal full literature search was conducted from October 2022 – March 2023 using the strategy outlined below.

Stage 1 Identifying the research review question

An initial broad review question was formulated:

> ***To discover what is known about the transition of experienced critical care nurses into an Advanced Critical Care Practitioner (ACCP) role, and how does the experience influence their professional identity and positionality within the healthcare team.***

Unlike a systematic review which requires a more precise research question to be answered, a scoping review entails a broader research or review question to be formulated. A preliminary search of the databases and search engines using the initial keywords of 'Advanced critical care practitioner', 'professional identity' and 'transition' yielded no empirical studies or other literature. This confirmed that the research question had not already been answered through previous research. Searching for 'Advanced critical care practitioner' in isolation provided less than ten articles but these were limited to discussion papers, commentary or quantitative studies focused on clinical efficacy of the role. The

aim of the scoping review was broadened to allow inclusion of literature reflecting other advanced practice nursing roles in other settings:

> ***To discover what is known about the transition of nurses into advanced practice roles, and to explore the concepts of professional identity and positionality within the wider team for nurses in these roles.***

Three objectives were developed to help frame the scoping review:

1. To identify factors that pertain to the transition process for nurses moving into advanced practice roles.
2. To explore how nurses perceive their professional identity when transitioning into their new role.
3. To examine how positionality and professional relationships with others are experienced by nurses transitioning into advanced practice roles.

Stage 2 Identifying relevant studies

To ensure clarity about the scope of the review, it was essential that my review question had a clearly defined search strategy (Levac et al., 2010). The use of models to aid the framing of review question and search strategies, such as Population, Intervention, Comparison, Outcomes (PICO) or Population, Exposure, Outcomes (PEO) are widely established in health research (Evans, 2022). However, I chose to adopt the model of Population, Concept, and Context (PCC) which is specifically recommended for scoping reviews (Peters et al., 2015). The original PCC was widened for the main literature search due to the paucity of studies specifically about ACCP's (See Table 5).

Table 5: PCC framework used in this scoping review

	Description
Population	Registered nurses working in an advanced critical care practitioner role. *This was expanded to incorporate other advanced nursing roles.*
Concept	The experience of the transition process, and the impact on professional identity and positionality within the wider healthcare team
Context	Intensive care; critical care *This was expanded to incorporate all healthcare settings, and all clinical specialities*

The formation of the PCC framework helped to define a range of keywords which were used in various combinations during the search (See Table 6). As explained earlier, the titles of advanced level roles in the UK is diverse (Leary et al., 2017) but some titles were found to be more prevalent, such as Advanced Practitioner and Advanced Nurse Practitioner.

Table 6: Primary keywords for scoping review search

	Keywords
Population	Advanced critical care practitioner Advanced pract* Advanced nurse pract* Advanced clinical pract* Nurse pract* Consultant nurse / nurse consultant
Concept	Transition Identity Professional identity Jurisdiction Boundar* / (boundary) work Third space Hybrid* Nurs* paradigm / paradigm of nurs*
Context	Critical care Intensive care (These keywords were later removed from the search parameters to allow discovery of literature regarding advanced practice from other clinical areas).
*** Denotes truncation of the root of a word to allow different variations of the word** **The search was refined through the application of Boolean operators, such as 'OR', 'AND' and 'NOT', to the keywords, which allows the search to be widened or narrowed at key stages (Livoreil et al., 2017)**	

A number of electronic databases and search engines were searched as they provided access to a range of nursing, healthcare, medicine, and social sciences resources. These included:

- Cumulative Index to Nursing and Allied Health Literature (CINAHL complete)
- Medical Literature On-line (MEDLINE)
- Science Direct Freedom Collection
- Web of Science
- Google Scholar
- British Library Electronic Theses Online Service (EThOS)

Initial limiters were applied where possible within the search engines, such as excluding all non-English language publications. The search was set to begin from 2010, as this reflects the publication of 'Advanced Level Nursing: A Position Statement' (Department of Health, 2010). Hand searching of reference lists of the papers selected for full-text review was undertaken to identify any further relevant papers not found in the initial searches, as suggested by Boland et al. (2017). Additionally, some of the databases identify when a paper has been subsequently cited by other authors, referred to as forward searching (Boland et al, 2017) which helped to uncover more recent studies that the search process had not identified. To acquire a sound exploration of the breadth of literature pertaining to the field of study, a variety of qualitative, quantitative, and mixed methods studies was sought from both published and unpublished (grey) literature. In addition, the websites of key organisations were searched for policy papers, guidelines, standards, and other documentation related to advanced level practice, as I considered these could add context to the emergence of these advanced level roles. Many of these documents have contributed to the background context outlined in Chapter 2 and can be found in Tables 1 and 2.

Stage 3 Study selection

This stage of the scoping review was to consider the identified records elicited through the database searches, to determine their relevance to be included in the final review, eliminating any studies that do not address the research question (Arksey and O'Malley, 2005). Similar to a systematic review, the establishment and application of inclusion and exclusion criteria (see Table 7) was required to ensure the selection of the evidence sourced for the review remained relevant to the review question (Tricco et al., 2018). The PCC framework (Table 5) and the keywords used in the search (Table 6) helped in the formation of the inclusion and exclusion criteria.

Table 7: Inclusion and exclusion criteria

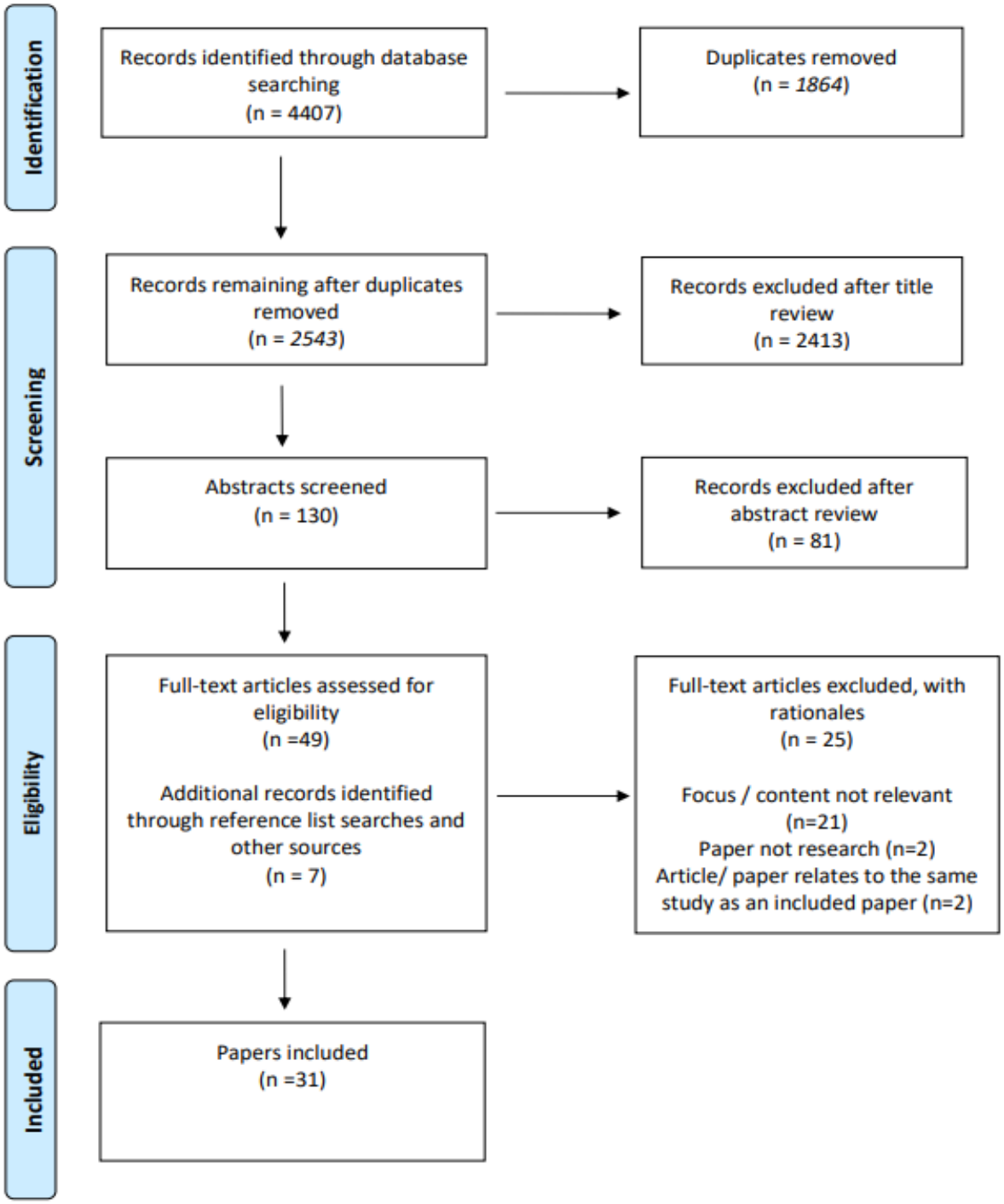
Inclusion criteria	Exclusion criteria
Publications relating to a population of nurses in advanced practice roles.	Research focusing on non-nursing advanced practitioner roles.
Studies focussing on the transition into advanced practice roles	Studies relating to transition of unqualified to qualified practitioners, or the transition of non-nursing professionals.
Studies exploring experiences of nurses moving into advanced practice roles	Studies relating to other elements of the advanced practitioner role (such as clinical outcomes). Studies relating to the implementation of new advanced practice roles from the perspective of

	others, such as colleagues, employers, or policy makers.
Studies exploring the professional identity of nurses working in advanced practice roles	Studies relating to professional identity outside healthcare (for example other professions such as teachers, lawyers etc.).
Studies from any methodology if the data relates to the scoping review question.	Non-research literature or policy or framework documents (such as general articles, discussion pieces, editorials)
Studies from 2010 – to current date (NB – this was later widened to include studies from 1999 onwards).	Non-English language papers

All records from the searches were imported into EndNote X8.2©, a bibliographic software system. This allowed the organisation and identification of duplicate citations which could be removed immediately. The next stage was the review of all article titles to remove irrelevant papers, followed by a review of the abstracts of each article, reducing the number of papers requiring further scrutiny to forty-nine. However in line with the scoping review process (Arksey and O'Malley, 2005), as the evidence base was being explored, an iterative evaluation and adaptation of the criteria was applied. The reference list for each of these papers was scrutinised to check for other possible papers not found in the database searches (Aveyard et al., 2021).

It was apparent that several pre-2010 studies were evidenced within some of the more contemporary studies, and these were retrieved, providing an additional seven papers deemed appropriate to be added for full text review. Following this last part of the literature review process, twenty-five papers were discarded. A final selection of thirty-one papers was included in this review because of their ability to contribute to the exploration of the concepts of interest relating to the research question. To aid transparency, the Preferred Reporting Items for Systematic Reviews and Meta-analysis (PRISMA) (Moher et al., 2009) which can be adapted for use in other types of literature reviews (Aveyard et al., 2021), has been used to show this literature search process (See Figure 3).

Figure 3: PRISMA flow diagram



Stage 4 Charting the data

Charting the data using a data extraction process for the final 31 studies allowed information pertaining to the studies to be extrapolated (Arksey and O'Malley, 2005). Current best practice guidance for scoping reviews stipulates the importance of data charting processes being made clear (Pollock et al., 2023; Tricco et al., 2018). Initially, each paper was read, and I completed a memo-style set of notes. Following this, a data-charting form was developed to allow key data items to be presented in tabular form, in preparation for collating and summarising during the following stage of the scoping review framework. The form was piloted on a small number of studies and then revised to ensure data related to the initial search question was elicited (Appendix 1). Key items of data included information about each paper, as well as a more iterative and narrative consideration of the findings and the relevance of this information to my research question. Data extraction and charting was undertaken solely by myself, as the doctoral student and principal researcher. To promote transparency and rigour, the process and findings were discussed within the supervisory process, with provision of the final papers and the data memos and data extraction table being made fully available for review. The summary of included studies in the scoping review is provided in Table 8.

Table 8: Summary of included articles (original search)

Author(s), date, title	Setting	Participants	Study design	What are the main findings?
Aagaard, K. et al. (2017) Identifying Nurse Anaesthetists' professional identity.	Denmark Hospital; anaesthesiology	RNAs – minimum of 1 ½ years of training Patients and RNA colleagues also included.	Focussed ethnography Data collection: Four phases including observation of practice; patient interviews; RNA interviews; RNA colleague interviews.	Core variable: ***Identifying the professional self*** Two subcore variables, and categories within these: ***Gliding between tasks and structures***: *being a piece in a puzzle; being a juggler of time and production* ***Depending on independence:*** *being important in an essential moment; being a co-pilot or following recipes*
Anderson, H. et al. (2020) Exploring the relationship between nursing identity and advanced nursing practice: an ethnographic study.	UK (England) Two GP sites (detail given re the organisations/ size variations)	9 ANPs and 5 nursing colleagues	Critical ethnography. Data collection: interviews, as well as observations.	Three themes: ***Conciliating Nursing*** – developing positive relationships with nurses ***Vertical Discounting*** – negative behaviours from nurses towards ANPs; also, by ANPs towards nurses ***Lateral Othering***. – ANPs expressing negative views of other ANPs; positioning selves against others
Andregård, A-C. and Jangland, E. (2015) The tortuous journey of introducing the Nurse Practitioner as a new member of the healthcare team: a meta-synthesis.	Sweden Location of all included papers not given (only 5 papers summarised).	26 papers included for analysis	Qualitative systematic review Search strategy information provided Meta-synthesis of data (method given)	Four themes: ***A threat to professional boundaries*** ***A resource for the team*** ***The quest for autonomy and control*** ***The ability to develop an interprofessional collaboration***
Ball, Carol and Cox, C (2004) Part two: the core components of legitimate influence and the conditions that constrain or facilitate ANP in adult critical care.	UK/ USA/ Australia/ NZ/ Canada Critical / intensive care units in five countries	39 nurses in advanced roles; country of origin and role details given for each participant.	Grounded theory Data collection: three sequential interviews and observation in practice.	Credibility as an essential and fundamental component in advanced practice. Six intervening conditions which impacted on the establishment and maintenance of credibility. **Constraining conditions**: *Conflict; Resistance; Gender bias* **Facilitating conditions:** *Overcoming resistance; Political awareness; Established values*
Barnes, H. (2015) Nurse practitioner role transition: a concept analysis	USA Location of included papers not given	24 articles included	Concept analysis method (Walker and Avant, 2005) Search strategy explained Findings follow the stages of the concept analysis process	Four defining attributes of NP role transition ***Absorption of the role*** ***The shift from provider of care to prescriber of care*** ***Straddling two identities*** ***Mixed emotions*** Two antecedents (events or incidents that must happen) to NP role transition identified: ***Personal /Environmental antecedents***

Author(s), date, title	Setting	Participants	Study design	What are the main findings?
Barton, T. D. (2007) Student nurse practitioners - A rite of passage? The universality of Van Gennep's model of social transition.	UK (Wales) Primary and secondary care.	10 student NPs 5 medical mentors 3 educators from teaching staff 3 senior nurse academic staff	Ethnography (practitioner ethnography). Data collection: over 2 years. Two sets of semi-structured interviews. Field notes.	Five transition themes – *social transitions; professional; clinical authority; clinical knowledge; clinical skills* A 3-stage process to transitioning into new role (presented in comparison of Van Gennep's (1960) 'Rite of passage' model). ***Identity loss [Separation]*** ***Learning new practice [Transition***] ***Returning to practice [Incorporation]***
Brown, M-A. and Olshansky, E. F. (1997) From limbo to legitimacy: a theoretical model of the transition to the primary care nurse practitioner role.	USA A range of employers from different healthcare providers	35 NPs who had just completed their course.	Grounded theory. Longitudinal study over 2 years. Data collection: Interviews at 1 month, 6 months and 12 months after graduation. 11 individual interviews; 24 via 7 focus groups.	Formation of a theoretical model: "From Limbo to Legitimacy." Four main categories: ***Laying the foundation*** ***Launching*** ***Meeting the challenge*** ***Broadening the perspective***
Cusson, R. M. and Strange, S. N. (2008) Neonatal nurse practitioner role transition: the process of reattaining expert status.	USA Neonatal services across 21 US states.	NNPs – 70 responses included.	Descriptive qualitative design (general principles of naturistic inquiry) Data collection: Survey questionnaire – 10 questions about transition and their experiences.	Four themes: ***First impressions: am I prepared?*** ***The transition*** ***Making it as a real NNP*** ***The helpers and hinderers***
Fleming, E. and Carberry, M. (2011) Steering a course towards advanced nurse practitioner: a critical care perspective.	UK (Scotland) An ICU in one hospital	9 trainee ANPs 5 consultant supervisors 3 CC nurses 4 CC nurse managers 3 junior doctors 1 divisional nurse director	Grounded theory. Data collection: individual focussed interviews.	4 major categories, with sub-categories: ***Finding a niche*** ***Coping with the pressures***. ***Feeling competent to do*** ***Internalising the role***
Jangland, E. et al. (2016) Between two roles – Experiences of newly trained nurse practitioners in surgical care in Sweden: A qualitative study using repeated interviews.	Sweden Surgical wards or emergency department, across five hospitals	8 qualifying NP students. All had completed their NP programme (unclear how soon afterwards this research was done, so period of transition into role not given).	Qualitative study (methodology not stated). Data collection: Interviews, with follow-up interviews.	Three categories in relation to transition into new role: ***Being accepted yet not accepted in the organisation*** ***A feeling of being in between two roles*** ***Positive patient response as a driving force***

Author(s), date, title	Setting	Participants	Study design	What are the main findings?
Kerr, L. and Macaskill, A. (2020) Advanced Nurse Practitioners' (Emergency) perceptions of their role, positionality, and professional identity: a narrative inquiry.	Ireland Emergency departments, across seven different hospitals	10 ANPs	Qualitative – narrative enquiry. Data collection: individual interviews	Five themes with sub-themes: ***Participants' career pathways*** ***Personal and professional transitions*** ***Role dimensions and core concepts*** ***Position within the organisation*** ***Emergent professional identity***.
Lawler, J. et al. (2020) Workforce experience of the implementation of an advanced clinical practice framework in England: a mixed methods evaluation.	UK (England) Across all regions of England; mixed specialties	Trainee or qualified advanced practice role holders (range of different job titles noted 528 responses	Mixed methods. Data collection: Online survey / questionnaires (n=528 participants); semi-structured phone interviews (n=15).	Majority of respondents were nurses. Key findings: ***ACP as a route for professional progression*** ***Professional uncertainty*** ***Challenge of unpaid work*** ***Working across the four pillars***
Lloyd-Rees, J. (2016) How emergency nurse practitioners view their role within the emergency department: A qualitative study.	UK (England) The ED in one NHS Trust	8 ENPs in the ED, with minimum of 1 years' experience	Qualitative study (methodology not stated). Data collection: Semi-structured interviews.	4 main themes, with 8 sub themes: ***Inter-professional working*** **-** *Within the ED; Outside the ED; with nurses; team culture* ***Role development*** **-** *Expanding the role; the future of the role* ***Education*** **-** *The role of education; the barriers* ***Motivation***
MacLellan et al. (2015) Nurse practitioner role transition a concept analysis.	Australia Location of included papers not given	No detail regarding the included papers provided.	Concept analysis methodology (Walker and Avant, 2011) Search strategy briefly explained Findings follow seven of the eight steps of the concept analysis process	Definition and key elements of transition. Defining attributes provided in the context of Bridge's' (2003) transition theory (*Endings; neutral zone; beginnings*). Antecedents (precursors) – include educational preparation, knowledge and skills for the role Consequences – negative ones include loss of confidence; loss of identity; role ambiguity
MacLellan et al. (2016) The enemy within: Power and politics in the transition to nurse practitioner.	Australia Four Australian states; a range of specialities including primary and acute care	10 newly endorsed (registered) nurse practitioners (NPs)	Qualitative – modified critical ethnography and focussed ethnography Data collection: Longitudinal over 1 year. Semi-structured interviews: participants were interviewed 3-4 times each. Some observation also conducted.	Main theme: ***The enemy within***. Two core elements: *Power and powerlessness* *Politics*
Mannix, K. and Jones, C. (2020) Nurses' experiences of transitioning into advanced practice roles.	UK (England) One Acute Medical Unit department in one hospital	6 trainee ANPs	Qualitative study (methodology not stated). Data collection: semi-structured interviews	Four themes: ***Transition*** ***Loss of professional identity*** ***Training*** ***Job satisfaction***

Author(s), date, title	Setting	Participants	Study design	What are the main findings?
Maten-Speksnijder et al. (2015) Driven by ambitions: The Nurse Practitioner's role transition in Dutch hospital care	Netherlands Six hospitals in the Netherlands	21 NPs	Descriptive qualitative design Data collection: semi-structured interviews with 9 NPs. Then two focus group sessions were held with another group of 12 NPs	Results presented in context with elements of Meleis's Framework: ***Nature of transitions*** ***Transition conditions*** ***Patterns of response – process indicators*** ***Patterns of response –outcome indicators***
Maxwell et al. (2013) Exploring the relationship between social identity and workplace jurisdiction for new nursing roles: A case study approach.	UK (England) 2 acute NHS hospital trust, both with two new nursing roles being implemented (n=4 roles).	4 new post holders, plus various others selected due to their relevance/ relationship to the new role(s).	Qualitative; critical realist case study Data collection: 2 phases. Phase 1 - semi-structured interviews); non-participant observation of committees; partial participant role holder observational shadowing; documentary analysis. Phase 2 - Follow up interviews with role holders (n=4) to test themes.	2 core themes of compliance and governance, which led to 2 types of new roles – ***fixer roles*** (created in response to problem or issue, such as targets); ***niche roles*** (evolved directly from departments in response to service development). 4 sub themes related to identity: ***Professional*** ***Speciality*** ***Organisational*** ***Relational***
Moran, G. M. and Nairn, S. (2018) How does role transition affect the experience of trainee Advanced Clinical Practitioners: Qualitative evidence synthesis.	UK Location of included papers provided (multi-national)	11 papers included for analysis	Qualitative – evidence synthesis. Search strategy information provided. Thematic synthesis of data (Thomas and Harden (2008) 3 stages method)	Six themes from the literature: ***Experience of change in work environment*** ***Orientation to role, environment, new colleagues and culture*** ***Appropriate mentorship***. ***Supported development of clinical skills***. ***Clinical supervision*** ***Appropriate education at MSc level***
Moyle, S. (2018) Identity crisis within the role of the emergency nurse practitioner? An exploration of autonomy and identity. PhD Thesis.	UK (England) Two settings – a nurse-led minor injury unit, and ED in acute NHS Trust	13 ENPS and 2 senior managers	Qualitative - case study Data collection: Four focus groups for the ENPs; semi-structured interviews with the managers.	5 themes (each with *sub-themes*): ***The key to identity: the role*** ***Value for money – perceptions*** ***The missing chapter: education*** ***The meandering river: career structure*** ***The expert practitioner: leadership and expertise***
Owens, R. A. (2018) Transition Experiences of New Rural Nurse Practitioners.	USA Range of rural locations	10 graduates from a FNP course who were now employed as FNPs; all in their first year of practice.	Phenomenological approach (not specified). Longitudinal study (1 year) Data collection: semi-structured interviews at 6 months and 12 months; 2nd interview questions informed by themes from 1st interview.	Five themes: ***Learning new skills, knowledge and roles*** ***Interactions and relationships with patients, nursing staff and providers*** ***Desire to practice in rural health*** ***Role transition to NP professional identity*** ***Professional identity and work satisfaction***

Author(s), date, title	Setting	Participants	Study design	What are the main findings?
Owens, R. A. (2019) Nurse Practitioner Role Transition and Identity Development in Rural Health Care Settings: A Scoping Review.	USA Location of included papers not given	145 articles included in final review (no detail given regarding these).	Scoping review (following Arksey and O'Malley, 2005) Search strategy information provided. Thematic synthesis of data not clearly explained.	Three themes: ***NPs in rural clinical practice*** ***Defining NP professional identity*** ***Role transition to NP identity***
Piil et al. (2012) The Impact of the Expanded Nursing Practice on Professional Identify in Denmark.	Finland Hospital outpatient department	5 ANPs, all from same department	Qualitative – case study Data collection: all participants undertook semi-structured interviews; eight observations of participants in practice; focus group discussion.	3 themes: ***Changing boundaries of practice*** ***Autonomy*** ***Self-esteem and confidence***
Pleshkan, V. and Hussey, L. (2020) Nurse practitioners' experiences with role transition: Supporting the learning curve through preceptorship.	USA Recruitment within one specific region. Practice settings not given.	16 NPs, minimum of three months in role (but no longer than five years)	Qualitative – hermeneutic phenomenology. Data collection: Semi-structured interviews – different approaches (face to face; Skype; phone)	Seven themes: ***Transition preparation and learning*** ***Preceptorship during role transition and learning*** ***Learning to care for complex*** ***Learning in clinical environment*** ***Transitioning to a greater autonomy and new responsibilities*** ***Embracing the role and identity confusion*** ***Transition reactions***
Taylor et al. (2022) Uptake of advanced clinical practice roles in the health service in England: Perspectives at the micro level.	UK (England) 6 NHS organisations in Greater London	18 ACPs. Demographics given re professional role; specialities; gender. No detail re length of experience as ACP or prior to this role.	Interpretive methodology with thematic analysis Data collection: Semi-structured interviews (by phone or face to face).	Three themes / motivational dimensions, with sub-themes: ***Personal and interpersonal motivations*** ***Professional and institutional motivations*** ***Structural influences***
Thompson, W. and McNamara, M. (2021) Constructing the advanced nurse practitioner identity in the healthcare system: A discourse analysis.	Ireland ANPs from emergency; geriatric; community care; surgical; and diagnostics)	12 ANPs Also 2 staff nurses; 8 clinical nurse managers; 1 director of nursing; 1 nursing project officer; 3 doctors; 2 allied health professionals (total 29 participants)	Qualitative – discourse analysis Data collection: 7 individual interviews; four focus groups held for other 22 participants.	Five main discourses relating to role construction: ***The value adding nurse practitioner*** ***In search of the nurse*** ***The educated taskmaster*** ***Negotiating a place in the healthcare system*** ***Supervision or control***

Author(s), date, title	Setting	Participants	Study design	What are the main findings?
Thompson, W. and McNamara, M. (2022) Revealing how language builds the identity of the advanced nurse practitioner.	Ireland ANPs from emergency; surgical; geriatric; community care; and diagnostics	12 ANPs Also 2 staff nurses; 8 clinical nurse managers; 1 director of nursing; 1 nursing project officer; 3 doctors; 2 allied health professionals (total 29 participants)	Qualitative – discourse analysis. Data collection: 7 individual interviews; four focus groups held for other 22 participants.	Four main discourses relating to role identity: ***The uniquely holistic identity*** ***The controlled identity*** ***The medicalised identity*** ***The independent powerful identity***
Timmons et al. (2023) The Advanced Clinical Practitioner (ACP) in UK healthcare: Dichotomies in a new 'multi-professional' profession.	UK (England) NHS Trusts delivering acute hospital or community services.	10 ACPs; 13 trainee ACPs; 14 ACP employers/ managers; 21 educators from ACP education courses.	Qualitative – Interpretative Description. Data collection: Semi-structured interviews (remotely conducted due to pandemic).	Three themes: ***Professional identity*** ***Differing definitions of ACP and advanced practice Professional regulation and recognition***
Wisur-Hokkanen et al. (2015) Experiences of working as an advanced practice nurse in Finland - the substance of advanced nursing practice and promoting and inhibiting factors.	Finland Primary care (n=16); hospital (n=5); other (n=3)	24 APNs	Qualitative – described as descriptive and explorative (exact methodology not given) Data collection: Focus group interviews (22 participants in 8 focus groups). 2 participants interviewed individually due to distance / travel.	3 main categories, with *subcategories*: ***The substance of APN*** ***Promoting factors in the development of APN practice*** ***Inhibiting factors in the development of APN practice***
Wood et al. (2021) Sources of satisfaction, dissatisfaction and well-being for UK advanced practice nurses: A qualitative study.	UK A range of primary and secondary care settings.	22 advanced practice nurses. Sampled from a cohort of participants from an initial study and chosen for follow up.	Qualitative study (methodology not stated). Data analysis using Braun and Clarke's Thematic Analysis (6 stages) Data collection: Semi-structured telephone interview	Four main themes, with *sub-themes*: ***The APN role and professional identity*** ***Feeling exposed*** ***Support for the advancement of the APN role*** ***Demonstrating impact***
Woods, L. P. (1999) The contingent nature of advanced nursing practice.	UK Five different practice areas (ED, NNU, ICU, gynae and respiratory	5 separate cases – each case comprised of ANP / student; consultant doctor / supervisor; senior directorate manager; unit/ ward CNM; HEI lecturer; junior doctor; nurse colleague.	Longitudinal case study design over 2 years. Data collection: Varied but included - interviews with ANPs and other nursing, managers and medical practitioners; observation of practice; self-reported role development diaries (completed for 5 consecutive days for each of the first 6 months in role)	A three-stage model of contingency – influenced by other interactions or factors. ***Stage 1: The idealism of reconstruction*** ***Stage 2: Organisational governance*** ***Stage 3: Resolution***

Additional scoping review search

The initial literature review was completed in early 2023, and included research published up to March 2023. Further monitoring of the literature continued throughout my doctoral journey, and I recognised the need to re-run the search as I approached the end of the study. The updated search reflects an increase in published scholarly and empirical research relating to advanced level practice in general, including the launch of the International Journal of Advancing Practice in January 2023. Supported by Health Education England's (now NHS England) Centre for Advancing Practice, the journal provides a specialist platform for promoting and sharing developments, achievements, and innovation relating to advanced level practice. Using the same parameters, a new literature search dated from March 2023 to Sept 2025 was conducted, and a further five papers were added. The summary of included studies from the second search are presented in Table 9 and incorporated in the discussion of key findings later in this chapter.

Table 9: Summary of included articles (additional search)

Author(s), date, title	Setting	Participants	Study design	What are the main findings?
Ablard, S., Kuczawski, M., O'Keeffe, C., Sampson, F.C., Mould, J. and Mason, S. (2025) A qualitative study exploring the experiences of advanced clinical practitioner training in emergency care in the South West of England, United Kingdom.	UK 5 regional EDs	18 ACPs 5 Consultant EC ACP leads	Qualitative design. Data collection: individual interviews Thematic analysis (Braun and Clarke)	Four themes: ***The master's in advanced practice could be better aligned with* the RCEM credentialing e-portfolio** ***EC ACP training needs some flexibility to reflect the individual – 'one size does not fit all'*** ***Supervision and teaching requires significant staff capacity that is often impacted by external pressures*** ***Unclear role expectations and responsibilities hinder role transition and impact role identity***
Chenou, A., Brillouet, L., Guillon, S., Bilbault, P. and Pelaccia, T. (2025) Characteristics of emergency nurse practitioner professional identity: a multicenter qualitative study.	France 5 hospitals – emergency departments	21 participants: -7 RNs; 3 physicians; 6 ENPs; 5 managers	Qualitative study – no exact methodology given. Data collection: individual interviews	Four themes, with sub-themes: ***A combination of skills in a variety of fields*** ***A pivotal professional, expert in the care pathway, at the interface with other emergency professions*** ***A dual identity: nurse and emergency professional*** ***A position that is still in its nascent stages, beset with uncertainty and obstacles***
Kuczawski, M., Ablard, S., Sampson, F., Croft, S., Sutton-Klein, J. and Mason, S. (2024) Exploring advanced clinical practitioner perspectives on training, role identity and competence: a qualitative study.	UK One UK region	14 participants – ACPs or tACPs Participants from primary / community care, and secondary care	Qualitative – exploratory study Data collection: focus groups – max 3 participants. Done online. Data analysis using Braun and Clarke	Four themes with sub-themes: ***Clinical training lacked structure and support*** ***Existing knowledge and experience appeared to act as both an enabler and inhibitor for ACPs, with implications for confidence.*** ***The ACP role and associated responsibilities are poorly understood by ACPs and the wider medical profession*** ***The ACP role is important, but changes are required to provide security to the role in the future.***
Li, Y., Want, C., Tan. And Jiang, Y. (2023) The transition to advanced practice nursing: A systematic review of qualitative studies.	China Location of included papers given - USA, UK, China, Europe	14 papers included for analysis Details provided	Qualitative systematic review. Search strategy information provided.	Three themes with sub-themes: ***Trudging along a narrow road*** ***Driving and restraining forces in the transition*** ***Embracing the new identity***
Ljungbeck, B., Carlson, E. and Sjögren Forss, K. (2025) Nurse Practitioners' Experiences of Transitioning to and Working in the Pioneering Nursing Role: An Interview Study.	Sweden	15 Nurse Practitioners	Qualitative interview study Data collection: individual interviews Data analysis – inductive content analysis	Four categories with sub-categories: ***Progressing to the next level – motivators of and perspectives on NP education*** ***Navigating loneliness and cultivating acceptance*** ***Enhanced person-centred care and supportive leadership*** ***Lack of regulation and management influence autonomy and efficiency in the NP role***

Stage 5 Collating, summarising, and reporting results

The purpose of this scoping review is to present an overview of published literature relating to the review question and aims, as well as to identify gaps in the evidence (Arksey and O'Malley, 2005; Daudt et al., 2013; Peterson et al., 2017). When presenting and considering any findings from this scoping review, it is important to remind the reader that scoping studies are not intending to provide a distinct synthesis of evidence, nor provide a judgement on the quality or importance of evidence. Instead, they provide an overview of concepts relating to the topic and research question (Arksey and O'Malley, 2005; Pollock et al., 2023; Tricco et al., 2018). The scoping review will be summarised and reported in three sections. Firstly, an overview of the nature and range of research studies included in this review will be presented, providing an outline of the nature and type of empirical research related to the review question. Following this, the findings of the scoping review are discussed in relation to the scoping review question and aims. Finally, I will conclude with outlining the gap in the evidence base which confirms the need for this research study.

Stage 6 Consultation

Arksey and O'Malley (2005) suggest that consulting with stakeholders, such as patients or other subject experts, adds value and rigor to the review process, through the provision of unique perspectives and expertise on the subject area. However, including consultation may present a number of challenges such as finding appropriate stakeholders, ensuring the stakeholders are supported to understand the scoping review process, and consideration of how to incorporate data from this stage into the wider findings (Levac et al., 2010). As this scoping review was to support the doctoral research study, it was not deemed appropriate or necessary to include this stage.

Key findings from the review

General description of included studies

The scoping literature review found no studies in relation to critical care nurses moving into Advanced Critical Care Practitioner roles, which supported my initial preliminary search. By expanding the Population and Context parameters for the search (see Table 5), a broader range of national and international evidence relating to nurse transition into advanced practice roles was elicited (see Table 8 – Summary of included articles (original search); & Table 9 – Summary of included articles (extended search)). Studies originating from the United Kingdom formed the majority of the final group of papers (n=16), with publications from USA (n=6), Ireland (n=3), Sweden (n=3), Australia (n=2), Finland (n=2), Denmark (n=1), France (n=1), China (n=1) and Netherlands (n=1) also contributing the evidence base. There was a dominance of qualitative studies in the literature reviewed (n= 30), with most authors (n=20) identifying a specific methodology, although other papers did not explicitly identify their

methodology (n=5). The remaining papers included a mixed methods study (n=1), concept analysis (n=2), and literature reviews (n=4). Of the four literature reviews, there was one scoping review using mixed evidence, one qualitative evidence synthesis and two qualitative systematic reviews.

The studies had participants from a range of clinical environments, including community / primary care sector (n=4) and specific secondary care or hospital settings (n=12). A high number of studies had participants representing a mix of clinical settings (n=16), with the remainder of the studies not specifying the speciality or location of their participants' work base (n=4). Only two studies focussed on intensive care advanced practitioners (Ball and Cox, 2004; Fleming and Carberry, 2011), although other acute and urgent care settings were represented (Aagaard et al., 2017; Ablard et al., 2025; Chenou et al., 2025; Cusson and Strange, 2008; Jangland et al., 2016; Kerr and Macaskill, 2020; Lloyd-Rees, 2016; Mannix and Jones, 2020; Moyle, 2018).

Reflective of the prolific variation of titles of advanced practice roles (Leary et al., 2017), a range of participant roles and titles are evident in the 31 studies. These include Nurse Anaesthetists, Advanced Nurse Practitioners, Advanced Practice Nurses, Nurse Practitioners, Emergency Nurse Practitioners, and Advanced Clinical Practitioners. Three studies included a more heterogenous range of participants who were in advanced level nursing roles (Ball and Cox, 2004; Lawler et al., 2020; Maxwell et al., 2013). The original role title or terminology used by the study authors will be used within the following discussion.

The included studies aligned to one or more of the scoping review objectives 1-3 (see Table 10) and the themes found from the literature will now be discussed in the following sections.

Table 10: Themes and sub-themes

Scoping review objectives	Theme heading	Sub-themes
1. To identify factors that pertain to the transition process for nurses moving into advanced practice roles.	Transition	• Drivers for changing role • The process of transition • Factors impacting on the transitional experience
2. To explore how nurses perceive their professional identity when transitioning into their new role.	Identity	• A shifting professional nurse identity • Establishing an advanced practitioner identity
3. To examine how positionality and professional relationships with others are experienced by nurses transitioning into advanced practice roles.	Positionality and professional relationships	• Inter-professional relationships • Intra-professional relationships

Theme 1 – transition

1.1 Drivers for changing role

The evolution of advanced level nursing practice draws on the policy, financial and organisational drivers for implementing new advanced level roles into healthcare organisations (as discussed in Chapter 2). Within this scoping review, a range of personal and professional drivers were shown to have been motivators for individual nurses to initiate a transition into a distinct advanced practice role.

A common finding within the literature was a desire to remain in clinical practice. However, moving into advanced practice roles was associated by many nurses as the only option for promotion and progression without following a more traditional management career route (Kerr and Macaskill, 2020; Lawler et al., 2020; Lloyd-Rees, 2016; Maten-Speksnijder et al., 2015; Taylor et al., 2022; Timmins et al., 2023). Nurses who had progressed to work in nursing management posts previously reported dissatisfaction with their roles, with a sense of becoming more distant from patients (Kerr and Macaskill, 2020). In contrast, working in an advanced practice role was described as creating a space for senior nurses to deliver better and consistent care to patients (Lloyd-Rees, 2016). This suggests that transitioning into advanced practice roles was viewed as a positive career enhancement decision, although it did present challenges. A lack of clarity and understanding about advanced practice roles, from patients, colleagues and employers was seen to impact on the training and transition stage, and provided a degree of uncertainty about the future opportunities and career stability (Kerr and Macaskill, 2020; Lawler et al., 2020; Lloyd-Rees, 2016). Despite these concerns, nurses reported clear advantages and benefits to undertaking the role, including being able to provide holistic care, address clinical pressures or improve care provision, ultimately to make a difference to their patients experience of healthcare (Lawler et al., 2020; Maten-Speksnijder et al., 2015; Timmins et al., 2023).

Additionally, the transition into advanced practice roles allowed nurses the opportunity to develop niche or specialist skills, facilitating new ways of working to improve the efficiency of patient care whilst meeting the service needs of the healthcare organisation (Maten-Speksnijder et al., 2015; Taylor et al., 2022). Attainment of new or specialist skills and knowledge for working at an advanced level of practice was viewed as central to the transition into the role, as well as being essential to gain more senior level responsibilities (Ljungbeck et al., 2025; Lloyd-Rees, 2016; Maten-Speksnijder et al., 2015; Owens, 2018; Taylor et al., 2022). This development of clinical expertise reflects the concept of mastery, which is described as a desire to develop and advance skills or knowledge to improve practice (Taylor et al., 2022). Concerns were found, however, that mastery is perceived as the attainment of new skills which are often aligned to medical practice, rather than specifically enhancing nursing practice (Lawler et al., 2020; Maten-Speksnijder et al., 2015). This view was rejected by nurses who clearly were driven to work

at an advanced level but they did not do so in order to replace doctors roles (Kerr and Macaskill, 2020; Taylor et al., 2022; Timmins et al., 2023).

Nurses were found to be motivated towards advanced level roles as an opportunity to advance the nursing profession, to enhance a sense of relatedness and contribution to the wider team, and to gain social purpose and satisfaction from seeing the impact on patient care (Mannix and Jones, 2020; Taylor et al., 2022). Improved job satisfaction was particularly noted in several papers, with differing reasons for how this occurs (Kerr and Macaskill, 2020; Lloyd-Rees, 2016; Mannix and Jones, 2020; Moyle, 2018; Owens, 2018; Taylor et al., 2022). For example, nurses spoke positively of enjoying good relationships with their patients, and viewed their role as providing stability within the workforce, which allowed them to provide high quality, expert care (Lloyd-Rees, 2016; Mannix and Jones, 2020; Owens, 2018). A sense of pride, the privilege of undertaking the role, and the appreciation of trust given to them from others were also found to be positive drivers for nurses (Moyle, 2018). Moyle (2018) drew attention to the link between job satisfaction and self-esteem, which is related to the concept of professional identity. This would suggest that having strong motivation to undertake a role transition, and finding the role provides greater job satisfaction, is key to being able to establish a new identity confidently.

Intrinsic (personal) drivers dominated the literature, but extrinsic motivators, which place prominence on rewards such as pay, also appear to be important. Transitioning into an advanced level role was viewed by some nurses as an opportunity to secure career progression and have their advanced role recognised through subsequent salary increases (Lloyd-Rees, 2016; Moyle, 2018; Taylor et al., 2022). It was viewed as important that employers recognised the advanced skills and knowledge gained during their training and transition into the role, as well as the substantive increase in professional responsibility of patient care (Taylor et al., 2022). The issue of pay is aligned to a sense of being valued for their advanced level of practice, and at times nurses perceived this to be unrecognised, leading to a sense of being seen as cheap labour (Moyle, 2018). Timmins et al. (2023) report that the NHS banding and pay structure has allowed for clinical roles to go up to Band 7, with Band 8 and 9 roles being mainly for managerial or other senior leadership roles. Whilst none of the studies gave specific banding details that would be expected for advanced level roles, typically NHS Jobs advertises qualified ACP and ACCP roles at Band 8a. However, Lawler et al. (2020) found that around a quarter of their respondents were banded lower than this, which could explain why some nurses felt that they were undervalued. Other factors such as the lack of clear role definitions and variations in the standards of educational preparation, using personal time for development, financial costs, and impact on personal lives were

also noted as potential barriers for nurses moving into advanced roles (Kerr and Macaskill, 2020; Lawler et al., 2020; Lloyd-Rees, 2016; Moyle, 2018; Taylor et al., 2022).

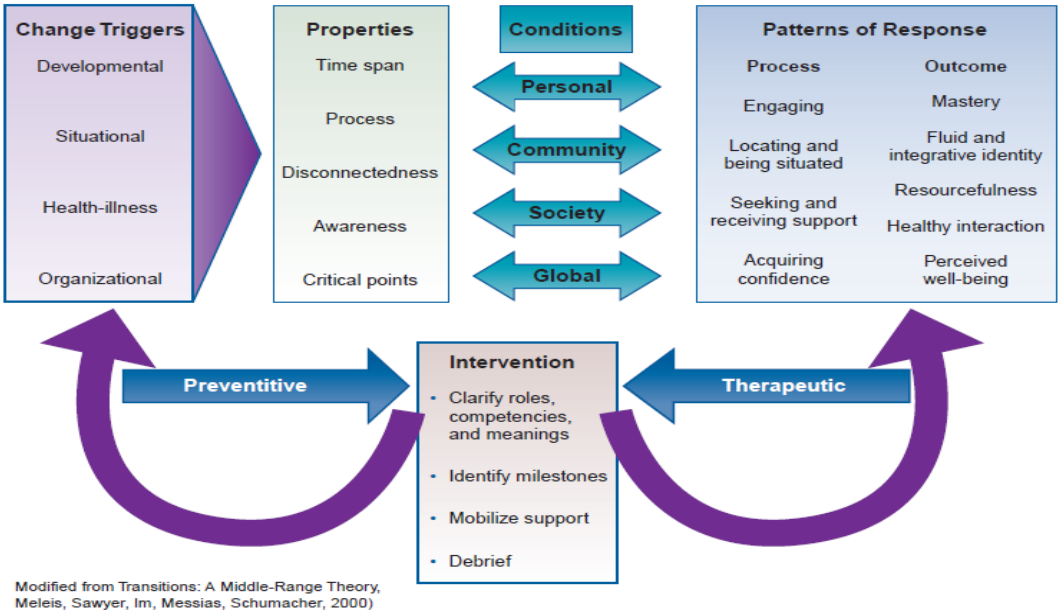
Overall, the literature has shown that developing autonomous, patient focussed care, and contributing positively to the wider healthcare team and service, are strong intrinsic motivators for nurses. However, considerations to external motivators such as salary, role recognition and the perception of being valued remain significant for some nurses and therefore may influence their transitional experience.

1.2 The process of transition

Within the scoping review findings, the role transition process for nurses moving into advanced practice roles has been discussed in reference to three existing transition theories – Van Gennep's (1960) *Rite of Passage* model; Meleis (2015; 2000) *Transitions: a middle-range theory*; and Bridges (2003) *Transition theory* (Barnes, 2015; Barton, 2007; Cusson and Strange, 2008; MacLellan et al., 2015; Maten-Speksnijder et al., 2015; Moran and Nairn, 2018; Moyle, 2018; Owens, 2019). The theories evident will now be summarised, as they offer a way of understanding transition as a process.

Barton's (2007) study drew on Van Gennep's (1960) model of social transitions, developed from the study of rituals undertaken by different societies when a social transition occurred. These rituals, or rites of passage typically occurred when there was a change in social status, for example coming of age, getting married, parenthood or death, and can also include change events such as undertaking a new professional role. Three stages - Separation, Transition, and Incorporation – explain how someone moves through different periods during their rite of passage. Barton's (2007) emergent findings generated a three-staged Model of Transition incorporating the stages of Identity Loss; Learning New Practice; and Returning to Practice, which was considered in relation to Van Gennep's model. The key findings from Barton's (2007) study will be considered later in the chapter. No other studies drew on Van Gennep's model explicitly, although Moran and Nairn (2018) acknowledged its contribution to understanding transition for advanced practitioners. Van Gennep's model focuses on the social and emotional elements of transition, but in contrast transition theory developed by Afaf Meleis (in collaboration others, over several decades, 1986; 2010; 2000), provides a more comprehensive framework. Several studies (Barnes, 2015; Cusson and Strange, 2008; MacLellan et al., 2015; Maten-Speksnijder et al., 2015; Moran and Nairn, 2018; Owens, 2019) referred to Meleis' work and in particular 'Transitions: a middle-range theory' (Meleis, 2015). This theory comprises of several inter-related and distinct components or concepts, which include change triggers; the properties of transition; transition conditions; pattern of responses; and interventions (Meleis, 2015) (see Figure 4).

Figure 4: Transitions: A middle range theory (Meleis, 2015)



It is proposed that transition is an internal process that the person will experience in response to a distinct change, and is characterised by a movement or flow towards something new for the individual (Meleis et al., 2000). In particular, situational transitions can occur within educational or professional roles and are described as a change in role function or scope of practice (Schumacher and Meleis, 1994). This type of transition reflects nurses making the decision to move into a new advanced practice role, with a resulting change to their professional position and status, which explains why some of the studies in the review referred to it. Meleis (2015) notes that there are several *properties* of transition, elements which can influence the transition process and therefore the experience and outcome for the individual. Properties include the time span for the transition; disconnectedness – a disruption or separation from the old; and awareness – the conscious process of making meaning of the change. Meleis (2015) provides a detailed framework to help shape the concept of transition. However, Gill and Shanta (2020) offer criticism that it is complex and less suited to professional role transition in comparison with Bridges' model.

Originating in the 1990's, Bridges transition theory (Bridges, 2003) was described within two papers in the scoping review (MacLellan et al., 2015; Moyle, 2018). Transition is said to occur through three phases - the Ending phase, the Neutral Zone, and New Beginnings phase (Bridges and Bridges, 2016). The Ending phase consists of the start to the transition, a phase in which the individual develops an awareness that a change to their current reality or status is happening. This phrase requires the

individual to let go of how things, and themselves, used to be, and is often associated with considerable emotional responses. Significantly, a sense of grieving could be experienced by the person losing part of their previous status, and so this needs to be recognised and replaced with something new as the transition progresses (Bridges and Bridges, 2016). The Neutral Zone can be seen as the in-between stage, but this phase is also a time of being in-limbo for the individual who encounters uncertainty as their new role and identity is not yet established. The third and final phase of New Beginnings occurs when the individual has a sense of 'being' in the new role, and has adjusted to the new values, expectations, and identity of this role (Bridges and Bridges, 2016). From the scoping review papers, the experiences and changing of identity for nurses moving through these stages will be discussed in more detail in the following section (Theme 2- identity).

The three frameworks and models all show a progression through the stages of transition over a period of time although some studies show the transition process to be non-linear, fluid and complex (Andregård and Jangland, 2015; Brown and Olshansky, 1997; Fleming and Carberry, 2011; Jangland et al., 2016; Mannix and Jones, 2020). Illustrating this, several studies used metaphors to compare the transition process to a journey (Andregård and Jangland, 2015; Mannix and Jones, 2020). For example, nurses described the transitional process to be like crossing into something unknown, whilst feeling adrift from what they used to be as a traditional nurse (Mannix and Jones, 2020). A more direct description of the transition process for advanced practitioners was as a 'torturous journey towards a partially unknown destination' (Andregård and Jangland, 2015: 10). Nurses in this study were found to be unclear as to where they were heading with their new role, regarding their autonomy and scope of practice, their professional identity, and how their emerging advanced practice fits within the wider healthcare team, which will be discussed later in this chapter (Theme 3 – positionality and professional relationships). To summarise, the role transition experience is a more complicated process than merely gaining a qualification or starting in a new role. It is necessary therefore to consider how internal or external factors influence the transition experienced of nurses moving into advanced practice roles.

1.3 Factors impacting on the transitional experience

A range of factors which are influential and impactful on a nurse's transition into an advanced practice role were revealed within the literature. One recurring aspect that promoted a successful role transitional process was through undertaking formal education preparation and establishing a strong practice learning experience as a foundation for stepping into an advanced practitioner role (Barton, 2007; Cusson and Strange, 2008; Fleming and Carberry, 2011; Kerr and Macaskill, 2020; Lawler et al., 2020; Lloyd-Rees, 2016; MacLellan et al., 2015; Maten-Speksnijder et al., 2015; Moran and Nairn, 2018; Moyle, 2018; Owens, 2018; Thompson and McNamara, 2021; Wood et al., 2021). Nurses indicated the

positive impact undertaking professional development had on their confidence for transitioning into their new advanced level role (Cusson and Strange, 2008; Fleming and Carberry, 2011; Kerr and Macaskill, 2020; Lloyd-Rees, 2016). As well as underpinning their new practice, education was equated with a change in professional status, as well as promoting role credibility within the wider team (Moyle, 2018; Thompson and McNamara, 2021). The acquisition of higher-level skills typically associated with medicine was an explicit focus for some nurses (Maten-Speksnijder et al., 2015; Thompson and McNamara, 2021), which suggests a role that is substituting for another professional group rather than specifically advancing nursing practice. More pragmatically, being able to blend new skills and knowledge within the nursing paradigm of practice was important to other nurses (Fleming and Carberry, 2011; Moyle, 2018; Wood et al., 2021). However, expectations about who should fund role education was perceived differently between the nurse and employers (Lawler et al., 2020; Lloyd-Rees, 2016). In Lawler et al.'s (2020) study of advanced practitioner's and student advanced practitioners in England, participants reported having to use their own time to undertake advanced practice training, whilst being expected to continue to fully undertake their normal employment role, sometimes in very different clinical specialities. Whilst this could be perceived as merely a matter of time management for the trainee, it is important to recognise that this has implications for the transitional process and the successful enactment of the advanced practice role.

Undertaking a formal course of study to work at an advanced level of practice requires the support of other professionals. The importance of mentors, preceptors or clinical supervisors for a successful transition into a new advanced practice role was evident in the literature (Ablard et al., 2025; Barnes, 2015; Cusson and Strange, 2008; Fleming and Carberry, 2011; Jangland et al., 2016; Lloyd-Rees, 2016; MacLellan et al., 2015; Mannix and Jones, 2020; Moran and Nairn, 2018; Moyle, 2018; Owens, 2019; Pleshkan and Hussey, 2020; Wood et al., 2021). Having an appropriate level of formal support for the nurse allowed the development of new skills and knowledge, and provided clear structure and guidance on how the new role would be enacted (Moran and Nairn, 2018). Additionally, when the support was effective, nurses reported better well-being, increasing confidence with their new role, and successful new identity formation (Cusson and Strange, 2008; Fleming and Carberry, 2011; Lloyd-Rees, 2016; Mannix and Jones, 2020; Owens, 2019). However, at times support was found to be variable in quality and quantity, which meant a less structured transition for some nurses, leading to stress and unhappiness in their new role (Jangland et al., 2016; Pleshkan and Hussey, 2020; Wood et al., 2021).

In addition to the formal support of mentoring and supervision, nurses recognised the importance of support from peers and colleagues, as well as other personal support mechanisms (Barnes, 2015;

Barton, 2007; Cusson and Strange, 2008; Fleming and Carberry, 2011; Li et al., 2023; Lloyd-Rees, 2016; MacLellan et al., 2015; Moyle, 2018; Owens, 2019; Wood et al., 2021). Peer support allows the experiences to be shared together, a reciprocal relationship which instils a sense of teamwork and encouragement (Barton, 2007; Fleming and Carberry, 2011; Lloyd-Rees, 2016; Moyle, 2018). Aligning to Wenger et al.'s (1998) Community of Practice (CoP), peers provide a social and learning environment for a community with shared characteristics. Typically, nurses found peers within the same professional group, such as other nurses transitioning into advanced practice roles (Fleming and Carberry, 2011; Lloyd-Rees, 2016; Wood et al., 2021). In contrast, Moyle (2018) reported some nurses perceiving certain medical staff as their peers, particularly as they felt they were working at a similar level in practice.

The impact of organisational factors, such as clarity regarding role expectations, and governance for the role, was also evident in the literature (Andregård and Jangland, 2015; Kerr and Macaskill, 2020; Lawler et al., 2020; Maten-Speksnijder et al., 2015; Maxwell et al., 2013; Moyle, 2018; Pleshkan and Hussey, 2020; Wisur-Hokkanen et al., 2015; Wood et al., 2021; Woods, 1999). A lack of role clarity was found to lead to role ambiguity, and as such nurses experienced difficulties in understanding their new role and responsibilities. Uncertainty was found in relation to role boundaries and jurisdiction of practice (Kerr and Macaskill, 2020; Ljungbeck et al., 2025; Maten-Speksnijder et al., 2015; Moyle, 2018; Pleshkan and Hussey, 2020; Woods, 1999). This was seen to manifest in a lack of autonomy, with the nurse being expected to revert to prior role expectations, ultimately leading to disillusionment of the advanced practice role and a failure to establish a new professional identity (Lawler et al., 2020; Wisur-Hokkanen et al., 2015; Woods, 1999). Additionally, restrictions to the advanced practice role also led to workload concerns, a reduction in motivation and job satisfaction and potentially a failure to retain experienced staff in the role (Maten-Speksnijder et al., 2015; Pleshkan and Hussey, 2020; Wisur-Hokkanen et al., 2015; Wood et al., 2021; Woods, 1999).

The transition process was strongly influenced by the expectations actions of key stakeholders such as consultants and senior managers, emphasising the external influences and power that impact on advanced practice roles (Andregård and Jangland, 2015; Maxwell et al., 2013; Woods, 1999). When taken into consideration with other influencing factors, such as mentorship and support, nurses moving into new roles within the organisation could experience greater isolation and uncertainty during their transition.

Theme 2 - identity

Within the scoping review, changes relating to a nurse's professional identity and the emotional responses to transitioning into new advanced practice roles were found (Andregård and Jangland, 2015; Barnes, 2015; Barton, 2007; Brown and Olshansky, 1997; Cusson and Strange, 2008; Fleming and Carberry, 2011; Jangland et al., 2016; Kerr and Macaskill, 2020; Lawler et al., 2020; MacLellan et al., 2015; Mannix and Jones, 2020; Moran and Nairn, 2018; Moyle, 2018; Owens, 2018; Piil et al., 2012; Pleshkan and Hussey, 2020; Thompson and McNamara, 2021; Timmins et al., 2023; Wisur-Hokkanen et al., 2015; Wood et al., 2021; Woods, 1999).

2.1 A shifting professional nurse identity

The development of new or unfamiliar knowledge and skills when moving into an advanced level role can lead to a loss of identity, particularly when this is associated with a perceived loss of nursing expertise (Andregård and Jangland, 2015; Barnes, 2015; Barton, 2007; Cusson and Strange, 2008; Fleming and Carberry, 2011; Jangland et al., 2016; Kerr and Macaskill, 2020; Mannix and Jones, 2020; Moran and Nairn, 2018; Wood et al., 2021; Woods, 1999). The concept of expertise in nursing is widely attributed to the work of Benner (1984) whose theoretical framework stipulates five distinct 'Stages of Clinical Competence' beginning at the novice stage and ending at the expert stage. Movement from novice through the stages into expertise is facilitated through the development of nursing knowledge, experiential learning and critical thinking skills and can take many years to achieve. However, the literature suggests nurses move from an expert and experienced status back towards a novice and inexperienced status as a trainee advanced practitioner, which in turn can affect their self-identity and confidence (Andregård and Jangland, 2015; Barnes, 2015; Barton, 2007; Cusson and Strange, 2008; Fleming and Carberry, 2011; Jangland et al., 2016; Kerr and Macaskill, 2020; Mannix and Jones, 2020; Moran and Nairn, 2018; Wood et al., 2021; Woods, 1999).

Transitioning into a new role can leave the nurse with a sense of losing their previous distinct professional identity before they have fully transitioned and formed a new or adapted identity. For some, the duality of having to remain in a previous substantive role, whilst undertaking the transition and preparation for a new advanced role, deepened the sense of dissonance between an existing and the new professional identity (Barton, 2007; Lawler et al., 2020). Other nurses described a sense of being professionally isolated because of their new working regime, finding themselves separated from their previous practice and routines (Fleming and Carberry, 2011; Wood et al., 2021). For example, nurses were no longer included in their previous nursing networks, and so were not involved in activities that they may have been previously, such as clinical handovers or communication processes (Wood et al., 2021).

Changes to a job title further reinforced a sense of disconnection, such as from a nurse job title to an Advanced Clinical Practitioner (Lawler et al., 2020; Wood et al., 2021). The increasing use of the title of Advanced Clinical Practitioner was found to suggest that individuals are moving from nursing towards a more medicalised advanced practice role and identity, which is subsequently afforded a higher status due to its alignment to medicine (Lawler et al., 2020; Timmins et al., 2023). Lawler et al.'s (2020) study reported that 19% of the respondents indicated that their original registered profession should be included in their role title. It is not clear how many of these respondents were nurses, but it does suggest that the heritage and professional status is important for them in retaining their distinct identity.

The lack of clarity about how advanced practice roles are positioned contributed to new advanced practice post-holders feeling like an imposter (Barnes, 2015; Brown and Olshansky, 1997; Kuczawski et al., 2024; MacLellan et al., 2015). Originating from work by Clance and Imes (1978), imposter syndrome (also known as imposter phenomenon) is when individuals, typically females, feel their status or achievements are attributed to luck rather that their skills, knowledge or qualifications, and this can lead to feelings of guilt and anxiety (Dean, 2023a). Caution is needed when suggesting imposter syndrome as a contributing feature of professional identity loss, as there are many other social and cultural factors which also influence the transition process and therefore the concept of identity, which are discussed within this review. However, it can be argued that individuals who feel unclear, uncertain, or unconfident about their practice and position in the wider team could have a more challenging time developing and embedding the new role and identity.

A range of negative emotions and feelings were found to be associated with the change to nurses' professional identity as they embarked on a transition from their established nursing role towards a new advanced practice role. These included feelings such as *distress, stress, apprehension, overwhelmed, uncertainty, challenging, scary, fear and feeling vulnerable* (Barnes, 2015; Brown and Olshansky, 1997; Fleming and Carberry, 2011; Jangland et al., 2016; Li et al., 2023; MacLellan et al., 2015; Mannix and Jones, 2020; Moran and Nairn, 2018; Owens, 2018; Piil et al., 2012; Pleshkan and Hussey, 2020; Wisur-Hokkanen et al., 2015). Nurses in one study described their practice as 'faking it' (Brown and Olshansky, 1997: 49), resulting from the struggle between expectations and their own feelings about their practice. Guilt was also reported to be a recurring emotion (Jangland et al., 2016; Moyle, 2018), with nurses expressing a sense of guilt for not feeling like a nurse anymore or not relating to nursing in the same way. In addition, feelings of guilt were evident when asking nurse colleagues to initiate an intervention for the patients. This appeared to be as a result of the dynamics of their role

changing , particularly as they would have been undertaking those elements of care themselves in their previous role (Moyle, 2018). Nurses also felt a sense of guilt that they had betrayed nurse colleagues by moving into this new role, reporting terms used by others such as 'deserting them' (Jangland et al., 2016: 97).

Whist there is convincing evidence of the negative emotions experienced during a transition, it is important to note that positive emotions and feelings are also associated by nurses moving into advanced practice roles. Nurses reported a sense of excitement by the move to working in advanced practice role despite any perceived challenges, with a positive enjoyment of the training and transition into the new role (Barnes, 2015; Cusson and Strange, 2008; Fleming and Carberry, 2011; Kerr and Macaskill, 2020; Mannix and Jones, 2020).

It is clear from the literature that nurses moving into advanced practice roles can experience changes to their own perception of their self and their professional identity. It is necessary therefore to consider how nurses manage this to re-establish their identity or develop a new identity which reflects their new role and new position within the wider team.

2.2 Establishing an advanced practitioner identity

The importance of nursing as a key element of the new advanced role identity was strongly evident, with many nurses remaining clear that their identity as a nurse was unchanged despite the different role they had undertaken (Kerr and Macaskill, 2020; Mannix and Jones, 2020; Moyle, 2018; Piil et al., 2012; Thompson and McNamara, 2021; Timmins et al., 2023; Wisur-Hokkanen et al., 2015; Wood et al., 2021). However, the literature showed an emerging position for the professional identity of advanced practice nurses. For example, a recurring discourse that advanced practitioners are defined against a medical paradigm was evident, with language used to describe the advanced practice nurses as replacing or substituting medical roles, thus being positioned as 'gap-fillers' (Lawler et al., 2020; Moran and Nairn, 2018; Thompson and McNamara, 2021; Timmins et al., 2023). In contrast, this positioning was viewed with a more optimistic perspective, as nurses recognised that their professional experience and heritage as offering value above and beyond being a replacement or substitution role (Fleming and Carberry, 2011; Thompson and McNamara, 2021; Timmins et al., 2023). Nurses felt they were better placed to deliver holistic care in their advanced practice roles, being more intuitive and responsive to the needs of the whole patient. Use of language such as 'caring' and not just being focussed on curing suggested this was a trait less common in other healthcare professionals, thus reinforcing their position as nurses, (Kerr and Macaskill, 2020; Thompson and McNamara, 2021; Timmins et al., 2023; Wisur-Hokkanen et al., 2015).

Whilst some nurses in advanced roles retain their nursing identity, the emergence of a multi-professional ACP role has contributed to a level of uncertainty regarding how professional identity is perceived (Lawler et al., 2020; Timmins et al., 2023). Seemingly innocuous role specific symbols, such as a change in the colour of a uniform or lanyard were found to differentiate a nurse from their previous role (Moyle, 2018; Timmins et al., 2023) and therefore influence their own sense of identity as they transition into a new advanced level role. Timmins et al. (2023) considered the multiprofessional nature of some roles against established professional sociology and identity concepts. Some ACP participants expressed satisfaction with retaining their original professional identity, however it was evident that there was a tension for others in how they saw their own position and identity within a new multi-professional role. The authors suggest that some participants saw a benefit to forming a new professional occupational group and identity specifically for ACPs, to reflect the multi-professional status of the role. This raises questions about how this new profession would be regulated, given the stance of the separate nursing and AHP regulator bodies regarding regulation of advanced level roles over the last few decades (Department of Health and Social Care, 2017; Nursing and Midwifery Council, 2017).

The enactment and positioning of advanced practice roles within the organisation was found to impact on how the transition and subsequent formation of a clear identity occurred (Aagaard et al., 2017; Maxwell et al., 2013; Taylor et al., 2022; Thompson and McNamara, 2021; Thompson and McNamara, 2022; Woods, 1999). A prominent new role identity was found when there was strong and cohesive inter-professional teamwork and respect, which could therefore promote acceptance of an advanced practice role (Maxwell et al., 2013). Described as a *speciality* identity, this type of identity supports 'belongingness', a social identity concept originating in social science and psychology literature (Willetts and Clarke, 2014). Having a strong sense of belonging to a specific team positively enhanced an individual's professional identity, through having greater self-esteem, trust and respect from colleagues, and autonomy with a wider jurisdiction of practice (Maxwell et al., 2013). Independent, autonomous practice is commonly cited as a key element of advanced level practice role, reflecting the expectation of complex decision making, problem solving and patient care management (Health Education England, 2017). Other studies in this review also considered autonomy as essential in establishing a professional identity within a new advanced practice role (Aagaard et al., 2017; Maxwell et al., 2013; Moyle, 2018; Piil et al., 2012; Thompson and McNamara, 2021). Therefore, restrictions or other barriers to enacting the role fully will lead to issues such as job dissatisfaction and difficulties with establishing a new identity.

Conversely, roles driven by managerial or organisation requirements, for example as a reaction to address targets, were more likely to lead to a lack of clear professional identity (Maxwell et al., 2013; Thompson and McNamara, 2021). The implications of this mean that advanced level roles introduced to fix an issue - such as medical staffing shortages – could mean a less naturally progressive, and more controlled and restricted role. Consequently, having controlled and unclear practice boundaries can impact on how the nurse transitions into their role and establishes their own professional identity (Aagaard et al., 2017; Fleming and Carberry, 2011; Maten-Speksnijder et al., 2015; Maxwell et al., 2013; Taylor et al., 2022; Wood et al., 2021; Woods, 1999). This creates a tension between wanting independent practice as an advanced practitioner but encountering the reality of working to a delegated role and associated responsibility.

The construction and assimilation of a new professional identity for nurses transitioning into advanced practice roles was shown to commence during the formal educational preparation or very early implementation of a new advanced practice role (Barton, 2007; Owens, 2018), continuing beyond the transition from student to practitioner. Whilst there is some evidence of nurses starting to feel more settled about their new role at the six-month stage, typically the research shows a period of one-to-two years is required to get a clearer sense of their advanced nursing role and to be able to practice with confidence (Andregård and Jangland, 2015; Brown and Olshansky, 1997; Cusson and Strange, 2008; Fleming and Carberry, 2011; Woods, 1999). This reinforces that professional identity formation when transitioning into an advanced practice role is a complex and ongoing process, and is influenced by the nurses social, professional, and organisational contexts. The following section will explore how these contexts effect the positionality of the nurse moving into an advanced level role, and the professional relationships with others within the wider healthcare team.

Theme 3 – positionality and professional relationships with others

The degree of organisational readiness for new advanced practice roles has been shown to influence the level of understanding, support and acceptance of the role in the wider team, which in turn influences the nurse transition experience (Ablard et al., 2025; Andregård and Jangland, 2015; Ball and Cox, 2004; Jangland et al., 2016; Kerr and Macaskill, 2020; Kuczawski et al., 2024; Lawler et al., 2020; MacLellan et al., 2016; Maten-Speksnijder et al., 2015; Maxwell et al., 2013; Moyle, 2018; Taylor et al., 2022; Wisur-Hokkanen et al., 2015; Wood et al., 2021; Woods, 1999). However, within this scoping review, both inter-professional and intra-professional relationships were found to be affected following the transition of a nurse into an advanced practice role.

3.1 Inter-professional relationships

Professional relationships between medical doctors and nurses in advanced practice roles was considered within a number of papers (Aagaard et al., 2017; Andregård and Jangland, 2015; Ball and Cox, 2004; Barton, 2007; Fleming and Carberry, 2011; Jangland et al., 2016; Kerr and Macaskill, 2020; Lloyd-Rees, 2016; Maxwell et al., 2013; Moyle, 2018; Piil et al., 2012; Taylor et al., 2022; Thompson and McNamara, 2021; Thompson and McNamara, 2022; Wood et al., 2021; Woods, 1999). It was found that the advanced practice role presented a threat to professional boundaries, which in turn affected the advanced practitioner's jurisdiction of practice. Abbott's (1988) seminal work regarding professions recognises that jurisdiction is the legitimate right to undertake and claim certain elements of professional practice, and is considered through the concept of boundaries that different professional groups establish. Having jurisdiction infers a monopoly on specific practice, that is having exclusive right to perform actions or interventions and through establishing jurisdiction, power, status and knowledge become rooted within that group (Ernst, 2020). However, traditional boundaries and jurisdiction of practice may become blurred when new roles are implemented, which may require another professional group to acquiesce their own position, often leading to conflict or disputes (Cain et al., 2019).

It was found that some advanced roles were heavily influenced by doctors, with a reliance on doctors giving support and permission for the nurses' practice to evolve (Aagaard et al., 2017; Maxwell et al., 2013; Moyle, 2018; Piil et al., 2012). For example, nurses in Aagaard et al.'s (2017) study described being a co-pilot or 'following recipes', demonstrating a more controlled and medicalised focus to the role. Having an imposed restriction of jurisdiction or scope of practice, by doctors, resulted in feelings of frustration and disempowerment for some nurses (Aagaard et al., 2017; Kerr and Macaskill, 2020; Maxwell et al., 2013; Moyle, 2018; Woods, 1999). The challenges of positioning and establishing a clear scope of practice frequently led to interprofessional conflict, particularly concerning doctors but also within the wider team (Andregård and Jangland, 2015; Ball and Cox, 2004; Barton, 2007; Fleming and Carberry, 2011; Jangland et al., 2016; Lloyd-Rees, 2016; Moyle, 2018; Taylor et al., 2022; Thompson and McNamara, 2021). However, the familiarity of the advanced practitioner role to the immediate medical team appeared to have a positive effect on acceptance of the role, thus reducing the experience of conflict or role challenges (Lloyd-Rees, 2016; Maxwell et al., 2013; Taylor et al., 2022). Maxwell et al. (2013) suggested a category of identity known as *relational identity*, which is concerned with how the interpersonal relationships between the post-holder and others influences the acceptance and enactment of their role. They further explain that having an influential patron, such as a senior doctor to support the individual moving into a new role, can influence the wider team to do the same. However, it could be argued that the opposite could occur for nurses who are new to the speciality or an

organisation, as they would need to establish their new advanced practice role within a team who may not understand or support it.

Reflective of the wider debate regarding role boundaries and jurisdiction of practice, Ball and Cox (2004) reported conflict with doctors as being a result of the doctors' perception that the nurses were encroaching on medicine's 'turf', generating a power struggle at times. In this study, nurses demonstrated a combative narrative regarding conflict situations, for example 'choosing which hill to die on' (p.15) when considering how to manage a situation. Fleming and Carberry 's (2011) participants also reported challenges to their new role from the medical team, particularly junior doctors who had a limited time within the critical care speciality. In this study, the initiation of the new role was seen as a threat to the training opportunities for these doctors. Similar concerns about medical staff feeling threatened by advanced practice nurses was also seen in other studies (Andregård and Jangland, 2015; Barton, 2007; Thompson and McNamara, 2021), which promotes the potential for a deterioration of interprofessional relationships. Resistance and a lack of acceptance of the role by medical staff was seen to manifest in different ways, for example reluctance or even refusal of a referral or request for advice, particularly from doctors outside of the immediate team (Jangland et al., 2016; Lloyd-Rees, 2016).

Some nurses found their new advanced practice roles were often held up to be 'not on par' (p.10) with doctors, and generally positioned on a lower level in terms of education, role scope and recognition (Thompson and McNamara, 2021). However, when advanced practitioners were viewed as contributing to the medical teams efficiency, they appeared to be more tolerated to undertake practice considered as being within medicine's jurisdiction (Taylor et al., 2022). It could be seen therefore that gaining recognition and validation from medical staff appeared to be important, with the establishment of credibility an essential component of the acceptance of advanced practice role holders (Ball and Cox, 2004; Kerr and Macaskill, 2020; Lloyd-Rees, 2016).

A significant and seminal piece of work in the field of critical care was undertaken by Ball and Cox (2004), who considered the credibility of the advanced practitioners in relation to three groups - other nurses, doctors, and managers/employers. Establishing credibility for medical staff was described as the most challenging, as they expected the post-holder to have published, presented at conference, or be undertaking clinical research. However, managers or employers viewed credibility as measurable outcomes such as reduced patient length of stay and other quality of care measures. Differing views of the measure of credibility was held by each group, which suggests that the nurses may have conflicting expectations placed upon them by different members of their team. In addition, wider organisational

level constraints around the scope or jurisdiction of practice also compound the perceived disparity between role expectations and role reality (Aagaard et al., 2017; Andregård and Jangland, 2015; Ball and Cox, 2004; Kerr and Macaskill, 2020; Lawler et al., 2020; Maten-Speksnijder et al., 2015; Woods, 1999).

The perceived medical domination of advanced practice roles may be compounded by the requirement of doctors to undertake a supervisory role during the training and transition period (Taylor et al., 2022; Thompson and McNamara, 2022), with one nurse describing this situation as 'the fox guarding the henhouse' (Thompson and McNamara, 2021: 9). Consequently, when advanced practitioners were not afforded independence and role autonomy that is seen to be a core privilege of working at this level, this reinforced the traditional power-based hierarchy which positions doctors above all other professions, keeping responsibility for managing patient care (Thompson and McNamara, 2021).

Despite the challenges of a changing role and position within the healthcare team, it was evident that the advanced practitioners persevered to establish themselves and their role with colleagues, particularly doctors. Positive relationships with doctors, particularly those inexperienced in the clinical speciality, were improved as a result of the teaching and support given to them by advanced practitioners, which acknowledged the continuity and expertise in a clinical area that an advanced practice nurse brings (Andregård and Jangland, 2015; Ball and Cox, 2004; Thompson and McNamara, 2021; Wood et al., 2021). Other strategies employed included maintaining a professional dialogue, describing this as talking the right language (Lloyd-Rees, 2016), reinforcing through explanation what their role is (Jangland et al., 2016), and actively inserting themselves into new opportunities such as medical staff meetings, thus promoting visibility of themselves within medical environments (Ball and Cox, 2004).

The impact of traditional medical dominance and control of the advanced practitioner's scope of practice was not an uncommon finding in this review. However, the evidence also suggests nurses in advanced practice roles experience significant changes with their relationships with other nurses, which will now be explored.

3.2 Intra-professional relationships

The scoping review reported advanced practice nurses experiencing negative or disruptive behaviours and attitudes from nurse colleagues, which manifested in differing ways, including distrust and resistance (Anderson et al., 2020; Ball and Cox, 2004; Jangland et al., 2016; Kerr and Macaskill, 2020;

Ljungbeck et al., 2025; Lloyd-Rees, 2016; MacLellan et al., 2016; Taylor et al., 2022; Wisur-Hokkanen et al., 2015; Wood et al., 2021). Distrust and resistance from nurses to their new advanced nursing practice colleague was reported (Anderson et al., 2020; Ball and Cox, 2004; Chenou et al., 2025; Jangland et al., 2016; Lloyd-Rees, 2016; MacLellan et al., 2016; Taylor et al., 2022; Wisur-Hokkanen et al., 2015). Ball and Cox (2004) found resistance, generally initiated by other nursing staff, was a constraining factor in the transition process of advanced nurse practitioners. Participants in this study reported negative attitudes displayed by nurse colleagues, such as discussing and criticising the advanced practitioner with others in the team. Similarly, distrust of the advanced practice nurse was noted by negative gestures and comments made by nurses (Wisur-Hokkanen et al., 2015), whilst Jangland et al.'s (2016) participants found clear opposition from nurses to their new role, manifested in challenges to their competence which some of the participants found unexpected and concerning.

Typically, resistance from nursing colleagues presented in the form of resentment or even refusal to help when this was requested by the advanced nurse practitioners, although it seemed that nurses responded more positively when a doctor asked for a similar activity (Lloyd-Rees, 2016; Taylor et al., 2022). Overt and covert negative behaviours and attitudes by nurses manifested in a variety of ways, including hostility, disempowerment, and lack of support. The withholding of knowledge and information by other senior nurses was also experienced by the nurse practitioners, leading to an inability to undertake their full range and scope of advanced practice (MacLellan et al., 2016).

Not being recognised or acknowledged as being part of the nursing workforce anymore diminished their impact and influence, which could then be detrimental to the transition experience and to being able to establish a new identity (Anderson et al., 2020; Kerr and Macaskill, 2020; Wood et al., 2021).
Anderson et al. (2020) found marginalisation of some ANPs by nurse colleagues occurring. Described as *Vertical Discounting*, a lack of support, respect, or acceptance of the advanced practice nurse was evident. This appeared to be underpinned by a perception that the ANPs were seen to be positioned closer to medical colleagues and focussed on undertaking medical roles, and not necessarily maintaining the essence of nursing (Anderson et al., 2020).

The implications of these findings appear to show a dissonance between how nurses and advanced practitioners view the positioning of such roles. However, whilst the literature spoke clearly about advanced practice nurses being recipients of negative behaviours, there is some suggestion that the advanced practitioners deliberately seek to position themselves as being different or separate from their nurse colleagues. For example, participants in Piil et al.'s (2012) study viewed themselves as being

elite and different from 'ordinary nurses' (p.333), suggesting that they positioned themselves as superior in some way. The authors do not report about this specifically, but it could be inferred that this may generate potential issues with professional relationships within the wider nursing team. In contrast, some advanced practice nurses were explicitly expected to try not to establish themselves as better than nurse colleagues, but instead to remain equal (Wisur-Hokkanen et al., 2015). This was explained against the existing professional culture within the nursing team, illustrating the need for wider support from the organisation to help establish advanced level roles.

The significance and impact of organisational support, culture and clarity of role expectations have been discussed previously in this review. With particular relevance as to how the role is considered by the nursing team, the literature presents mixed evidence as to whether remaining in the same department or team is advantageous in establishing a new advanced practice role (Andregård and Jangland, 2015; Cusson and Strange, 2008; Maxwell et al., 2013). In their systematic review, Andregård and Jangland (2015) found that the transition into a new advanced practice role was easier if the team knows the nurse already, although they also suggest that it can be challenging for nurses to re-establish themselves as an advanced practitioner with what could be seen as a 'higher' role than before. Similarly, having worked as a neonatal staff nurse prior to becoming a qualified neonatal nurse practitioner (NNP), many of the NNPs reported positive experience of staying or returning to their previous hospital and unit (Cusson and Strange, 2008). This offered a level of comfort through being familiar with the organisation, process, and the wider team. However, it also increased the risk of negative attitudes and behaviours from nurse colleagues who expected them to 'earn' their acceptance as an NNP. The issue of familiarity within a particular organisation, and in particular its culture, values and history, was also considered by Maxwell et al. (2013). The findings imply that a new post holder from within the organisation (or team) was viewed as belonging to the organisation and so would understand how things are usually done. This was seen as beneficial in establishing trust and confidence in the new role, leading to positive professional relationships. However, remaining as part of a previous team or organisation could also lead to the continuation of unwanted cultural or professional dynamics which could challenge the establishment of new advanced level practice and professional jurisdiction. This situation was found to be reversed if the individual was new to the organisation, in that they found acceptance into the new team less problematic than someone known to the team, but found more challenges navigating the systems, culture and routines (Cusson and Strange, 2008).

It was evident that some advanced practitioners actively aimed to establish their new role, whilst ensuring positive intra-professional relationships (Ball and Cox, 2004; Fleming and Carberry, 2011).

Strategies to overcome resistance employed by some practitioners included establishing credibility for the role, and through developing positive relationships with the wider nursing team (Ball and Cox, 2004). Examples of this was through actively working alongside the nurses in the bedspace, responding when asked to help with nursing care, as well as role modelling, teaching, and giving positive feedback. Similarly, participants in Fleming and Carberry's (2011) study found helping with direct nursing care a positive strategy in developing new relationships as a tANPCC. These participants had little if any exposure to others in a similar position, which led to role uncertainty and conflict within the wider team as they tried to establish themselves. The trainees found that actively being involved in helping nurses in the bedspace helped them to find a way to fit in and reassure their nursing colleagues, thereby reducing their isolation and uncertainty in their new role. However, other studies found the need to disengage from the previous nursing role and team in order to promote successful transition into the new role (Barnes, 2015; Lawler et al., 2020; MacLellan et al., 2015; Maten-Speksnijder et al., 2015), which would imply a need to resist undertaking previous elements of their nursing practice as a means to placate nursing colleagues.

The literature has shown that implementation of new advanced practice roles in healthcare teams can affect inter- and intra-professional collaboration and relationships. Nurses transitioning into a new advanced practice role must therefore negotiate and manage any challenges to establish themselves in their role. The reasons for the divisiveness within the healthcare team are varied but situating these findings in relation to social and cultural theories and concepts drawn from the literature search may help to illustrate how role positionality and identity evolve.

Social positionality theories and concepts

Anderson et al.'s ethnographic study of ANPs in primary care (2020) employed Positioning Theory to explore the dynamic relationships between the ANPs, GPs and primary care nurses. Positioning Theory (Harré and Moghaddam, 2003) offers a theoretical lens which considers that the rights and duties of individuals and groups are influenced by wider social, cultural, political and historical factors. A key principle of this theory is that individuals utilise actions and narratives to claim a position within a wider group, for example the narrative of what it is to be a nurse, or what it is to be a doctor. This positioning in turn ascribes specific rights, duties and obligations for that position. Additionally, it enables the challenge of others who may encroach on that position, thus positioning others as being different. Anderson et al. (2020) observed interactions, physical signs and symbols (such as seating or office arrangements), and traditional hierarchical attitudes which all contributed to a complex set of positioning between the different individuals. This in turn impacted on how the ANPs established their

professional identity. Additionally, for nurses working in advanced practice roles, the dynamics of positioning (or positionality) relate to their individual agency within the role. Agency refers the degree of autonomy to practice, and is enacted within the context of relationships, social positioning and culture (Chulach and Gagnon, 2016). Arguably, Positioning Theory is therefore a useful lens to understand the interpersonal dynamics that can occur in occupational spaces (Møller et al., 2023). However, a limitation of the theory is its focus on narratives and stories, which could be viewed as dominating other forms of positioning activities, such as the myriad of physical, symbolic or behavioural acts which can occur in the healthcare environment.

Other studies turned to French philosopher and sociologist Pierre Bourdieu to provide insight into how social and cultural interactions and behaviours influence how professional identity is formed and understood, and how individuals transition into an advanced practice role (Kerr and Macaskill, 2020; Kuczawski et al., 2024; Moyle, 2018). Bourdieu (1972; 1984) offers a 'Theory of practice', which frames an understanding of how social structures and individual agency are constituted, and how shifting dynamics impact on the stability and positioning of the individual. The premise of the theory is that individuals are connected to their social and material world, which are influenced through pre-constructed principles and perceptions held by the individual. Bourdieu presents a series of interwoven key concepts or thinking tools to underpin his theorisation. Most notably, the concepts of 'field', 'habitus' and 'capital are often depicted as interwoven and related to each other, as shown in this simplified equation – **[(habitus) (capital)] + field = practice**.

Bourdieu describes habitus as the ingrained dispositions that form a subjective set of norms for an individuals' practices or actions (Bourdieu, 1990). Habitus is both structured and structuring. It is structured as dispensations, for example someone's perceptions, habits and attitudes, are shaped by the individuals' personal and professional background and life experience. Historical, professional and personal values, education and knowledge all contribute to the formation of habitus. These are brought to the fore in the practice 'field', thus structuring current and future practices and behaviours (Grenfell, 2012). Habitus is considered an individual concept which is durable over time, although it is possible that habitus can be reframed in response to changes in life experiences. However, similar or shared habitus can occur as a result of individuals having the same characteristics and socialisation within a field (Bourdieu, 1990). Critical care nurses will have a degree of similar habitus in the sense of their experiences, knowledge, values and other dispensations regarding the nature of their professional identity and role expectations.

Bourdieu (1990) considers the field to be a 'social space', an organised, social system which locates different individuals interacting through relationships. Furthermore, he proposes that the field is a boundaried space, a place of power, rules, hierarchy and potential conflict. Individuals are positioned within the wider structure of the field, and as such their position is imposed to some extent. Bourdieu expands this concept to suggest that a social world is made up with multiple sub-fields, each with their own rules and expectations (Grenfell, 2012). For example, nurses working in critical care are positioned within the professional field of nursing and the speciality field of critical care. Additionally, they are also positioned in the more dominant and influential wider organisational and professional hierarchical fields. One's position in a field is not fixed; positioning within the field can become dynamic as individuals seek to improve or alter their position (Bourdieu, 1990). This occurs when individuals change role, such as moving into an advanced practice role, and is achieved through adjustment of their habitus or leverage of their capital.

The concept of capital is significant as a means of distinguishing individuals from each other. It can be used as a resource to leverage advantages within the wider field. Capital therefore represents a form of power and so possessing the right type and amount of capital is advantageous in securing greater hierarchical positionality in the field. Three fundamental types of capital are identified (Bourdieu, 1986). Economic capital typically relates to wealth and other assets but could also include access to funding sources or salary (banding). Social capital is enhanced through relationships, networks, or contacts through other groups that the individual has access to. Cultural capital is an accumulation of knowledge, attitude and skills which are core to the individual's status. Bourdieu (1989) later acknowledged symbolic capital which is concerned with prestige and status.

The interaction between habitus, field and capital shapes the relationship an individual has within a wider society, which in turn is affected by the behaviours and beliefs of the individuals within the space (Piedrahita Sandoval et al., 2025). Bourdieu's toolkit offers a sound foundation for understanding identity and positionality of ACCPs in their wider healthcare teams.

Identifying the gaps in the evidence base

The scoping review has revealed a range of published research and literature that relates broadly to the concepts of transition, professional identity and positioning of roles with in healthcare teams. However, the review has revealed several gaps in the literature which supports the justification for this study.

Firstly, the scoping review has shown that there has been no published research that relates to my research question directly. A search for literature regarding ACCP roles provided a very small amount of

mainly quantitative studies which considered the clinical efficacy of the role, but as these had no relation or relevance to my question, they were disregarded. Widening the search parameters revealed only a few studies that related specifically to the population (nurses in advanced practice roles), context (intensive or critical care) and the concepts of interest (transition, professional identity and positionality within the team). Therefore, the speciality of critical care and the distinct tenets of the nursing and advanced practice nursing roles are not fully explored or understood. This exposes an unexplored workforce issue relating to the recruitment and transition of nurses into new ACCP roles.

The search parameters were further extended to uncover as many related studies as possible which could contribute to exploring the topic areas. This meant that several older studies were included, which do pre-date a number of key policies and frameworks, including the 'Multi-professional framework for Advanced Clinical Practice in England' (Health Education England, 2017) which are influential in the advanced practice landscape of today. Similarly, less than half (15 out of 36) of the papers are concerned with advanced practice in the UK. This means the professional, cultural and political influences may differ and so some caution must be taken in respect of those findings. Therefore, to address this, the context of contemporary UK advanced level practice needs to be the focus of new research to ensure potential role holders, employers and other stakeholders are fully informed.

Furthermore, the extant literature exploring the lived experience of nurses undertaking a transition into advanced practice roles has only been considered through a phenomenological lens by two of the papers in the scoping review. These were both studies conducted in the USA, and neither was concerned with nurses in critical care, nor did they explicitly employ Interpretative Phenomenological Analysis. Other qualitative studies were included but these aim to generate distinct findings such as new theory or providing observations. The key aim of this study is to explore and understand the specific experiences of the critical care nurses, again with a view of providing insight to better inform others considering this role.

Chapter summary

In summary, it is not possible to discern from the literature the perspectives of the nurses currently in substantial or trainee ACCP posts regarding their experience in undertaking a transition into a new and unique advanced role. Furthermore, there is a lack of understanding about their professional identity or how professional relationships are affected, highlighting the need for research in this area. Utilising IPA to frame the research will address a methodological gap, providing a unique approach to studying a

phenomenon which has not been investigated before. The following chapter will examine the philosophical and methodological approach used to underpin the research design in more detail.

Chapter 4 Methodology

Introduction

This chapter will discuss the methodological approach which underpinned the processes utilised to address the research question and aims. The chapter will begin with the presentation of the research question and aims. I will then outline and explain the ontological and epistemological positioning of myself as the researcher. The inter-related concepts of ontology, epistemology, methodology and methods underpin and guide how the research is structured (Holloway and Galvin, 2017). It was therefore necessary to explore and justify my ontological and epistemological position for this research to subsequently decide on the approach (methodology) required to address the research question, and the strategies (methods) used to undertake the research. Consideration of several rejected qualitative approaches will be provided before the rationale is presented for selecting Interpretative Phenomenological Analysis (IPA) as the most suitable methodology

Research question and objectives

The scoping review revealed a lack of empirical evidence regarding the experience of and impact on the professional identity of critical care nurses once they have transitioned into an ACCP role. The main purpose of this study is to explore the personal journey and lived experience of the nurse who has transitioned into an ACCP role, with the goal of understanding how they themselves makes sense of their own experiences. The research question was reviewed following the scoping review to ensure alignment to the philosophical framework selected:

What is the lived experience of critical care nurses who undertake the transition into an ACCP role?

Three objectives aligned to the research question were formulated:

1. To discover how critical care nurses perceive and navigate influencing factors during and following their experience of the transition into the ACCP role.

2. To explore how critical care nurses view their own professional identity and positionality within the healthcare team through their lived experiences of the transition into the ACCP role.

3. To formulate recommendations for future ACCPs, employers, workforce planners and education institutes to promote successful application of this role to meet the demands of critical care services.

Theoretical underpinnings

Ontology

Development of the research methodology began following consideration of my own ontological and epistemological positioning. These concepts are concerned with the nature of reality, and the nature of knowledge, respectively (Kivunja and Kuyini, 2017). Ontology can be described as how the researcher sees and interprets reality (Ritchie et al., 2014). My ontological perspective aligns to the idea that there are 'multiple realities' which are constructed through the interactions between participants, their environment, and on occasions the researcher (Parahoo, 2014; Polit and Beck, 2018). This reflects a critical realist approach, which takes the assumption that there will be many realities 'out there' but these are fluid and dynamic due to the influence of the social frames that the individual is situated (Cuthbertson et al., 2020). As a registered nurse, the concept of the individual person and the therapeutic, caring relationship are core elements of my professional identity. For example, an early lesson learned as a student nurse is that pain is "whatever the experiencing person says it is, existing whenever the experiencing person says it does" (McCaffery, 1972: 95). Transferring these principles to my role as a researcher, I consider that the subjectivity of personal experiences is valuable to gain understanding of the differing realities under scrutiny. It is these subjective and personal meanings, formed by the complex and multifaceted experiences and interactions in their lifeworld, that this study aims to capture.

Epistemology

Epistemology is concerned with "what is (or should be) regarded as acceptable knowledge" in relation to the focus of a particular investigation (Bryman, 2016:24). Careful consideration of my epistemological position was vital to determine the kind of knowledge that I sought to attain through this research. Interpretivisim seeks to discover underlying meaning through interpretations of reality, accepting that the knowledge of the world being explored is formed and influenced by the lived experience of the individual (Gray, 2022). This reflects my position, which recognises and values that different people experiencing the same phenomenon will construct different meanings through their interactions and impact of the social context. Positioning the research within an interpretivist epistemological lens acknowledges that as unique individuals, the participants bring their own experience, and therefore their own realities, to the fore.

As the researcher, I recognise that I need gain sufficient understanding of the participants experience of transition, and the impact on their professional identity and positionality. This requires my active engagement within the research process, which in turn ~~will~~ impacts on how the knowledge emerges

and how it is represented to the reader. Thus, new knowledge will be generated through my interpretation of the lived experiences of the participants as they recall their transition experience.

Research methodology – choosing a qualitative approach

Drawing upon my ontological and epistemological assumptions and considering the nature of what I wish to study, this research would not be best served by a methodological approach that seeks to test a hypothesis or theory. This approach relies on there being a single, objective reality. I have set out that I believe there are multiple realities, and these realities are subjective for the individual. Knowledge and understanding will be gained through exploring the perspective of the individuals situated in their social world. Therefore, a qualitative method is required to achieve this.

Due to the nature of qualitative research, arguably all qualitative methodologies share a common aim of understanding participants' experience, but they also differ in relation to the methods utilised within the research process (Holloway and Galvin, 2017). When I was reviewing the most appropriate methodology to frame this research it was important to ensure it aligned with how I position myself as a researcher, and the research question and objectives.

Ethnography was considered as this has been used to study advanced practice as discovered in the literature review (Aagaard et al., 2017; Anderson et al., 2020; Barton, 2007; MacLellan et al., 2016). Ethnography has its origins in social anthropology, and concerns itself with exploring and interpreting the behaviour of groups of people through immersion and observation of behaviours and rituals (Gray, 2022; Holloway and Galvin, 2017). This approach seeks to find the 'insider view', to understand the perspective of the participants and to find meaning in the situation. To achieve this, the researcher is required to be immersed in the environment with the participants for a substantial amount of time (Holloway and Galvin, 2017). However, this approach would focus on the collective social group perspective taken in the 'here and now' of the cultural or practice environment, rather than the individual lived experience.

A case study approach was also discounted. Case study methodology seeks to find the 'how', 'what' and 'why' (Cohen et al., 2018), allowing for a wider examination of the topic or phenomenon. In particular, it looks at relationships between, for example, the individual, service or organisation and policy (Denscombe, 2017). Cases can be either single or multiple units, which is useful in researching across more than one environment (Holloway and Galvin, 2017). Several papers within the scoping review utilised this methodology (Maxwell et al., 2013; Moyle, 2018; Piil et al., 2012; Woods, 1999). It could be

beneficial if the research question required the study of organisation practices or processes related to advanced practice roles, but this is not the aim of the study.

Finally, grounded theory was considered as a potential methodology. Originating from sociology grounded theory is concerned with social meanings and social interactions (Glaser and Strauss, 1999). There are several variants of grounded theory, but the key principle is to move beyond the collection and description of data in order to construct theory about the 'why', specifically looking at the processes and actions related to the phenomenon of interest (Glaser and Strauss, 1999). This is done iteratively, so the data analysis is interrelated with data collection as an ongoing process (Corbin and Strauss, 2015). Grounded theory has been used to study the phenomenon of advanced practice and identity as discovered in the scoping review (Ball and Cox, 2003; 2004; Brown and Olshansky, 1997; Fleming and Carberry, 2011). However, this methodology does not appear to be congruent with focussing and preserving the nuances of the individual experience, which is a core aim, and so was also discounted.

A phenomenological approach

These qualitative methodological approaches offer a means of inquiry in the study of transition, professional identity and advanced practice as seen in the scoping review but did not address the epistemological goal of exploring and interpreting individual transition experiences. In contrast to other qualitative approaches, phenomenology is concerned with exploring the lived experience of individuals who are immersed in the phenomenon of interest in order to interpret and understand the meanings of this experience (Cresswell and Poth, 2018). It offered an approach to discover how the experience is felt and conveyed by the individual and so resonated more closely to the aim of this research, which is to discover and interpret the lived experience of transitioning into an ACCP role. Phenomenology facilitates insight into the perceptions and experiences of the participants through allowing them to describe their experiences freely, recognising therefore the multiple of realities that ontologically exist (Bowling, 2014). Preliminary consideration of phenomenology concluded that this approach was an appropriate methodology to investigate the experience of the nurses who have transitioned into an ACCP role.

There are different philosophical approaches to phenomenology but broadly these are descriptive phenomenology (Husserl, 1900/01) and interpretative phenomenology (Heidegger, 1927). Whilst both approaches share an epistemological foundation, seeking to discover the meaning or nature of the phenomenon from the perspective of the individual, they also have a number of differences which

needs consideration in order to ensure the methodology is appropriate for the planned research (Matua and Van Der Wal, 2015).

Interpretative Phenomenological Analysis (IPA)

IPA's suitability to be used in the study of professional identity is underpinned by its three central theoretical principles of phenomenology, hermeneutics and idiography (Smith et al., 2022). Originally developed within psychology, IPA is a relatively new qualitative methodological framework emerging as an explicit methodology in the 1990's and has been used increasingly in qualitative healthcare research in the last several decades (Eatough and Smith, 2017). IPA is primarily concerned with investigating how individuals make sense of their lived experience and the personal meaning of that experience (Smith, 2019), examining phenomena from the first person perspective, and valuing the subjective knowledge that this generates (Eatough and Smith, 2017). IPA provides a rigorous and systematic approach and has been used to study the lived experiences relating to health and ill-health (Catchpole and Garip, 2021; Drozd et al., 2021; Gonder and Clarkson, 2024) as well as being concerned with the impact of identity in relation to gender issues, major life transitions and role change (Naylor et al., 2016; Smith, 1999; Wood et al., 2016).

Phenomenology

Originating from a philosophy background, phenomenology is described as the study of 'being', incorporating experience and existence (Larkin and Thompson, 2012). The origins of phenomenology are attributed to Edmund Husserl (1900/01) in the early twentieth century. Husserl considered the study of human sciences to be as valid as the more empirical and traditional (natural) sciences, and sought to challenge the primacy of the objective or positivist stance on knowledge and reality (Reiners, 2012). His argument was that the human experience is a source of knowledge, and the aim of phenomenology as both a philosophy and a method of inquiry was to discover this knowledge. Central to the foundations of Husserl's descriptive (or transcendental) phenomenology is the concept of life-world or '*Lebenswelt*', the world as lived in and experienced by the individual, and therefore only the person experiencing the phenomenon can understand it (Husserl, 1970). Phenomenology seeks to discover the exclusive aspects of the life-world experience such as the perception of self, senses and feelings of an individual (Van Manen, 2014) but Husserl (1900/01) argued that this examination of the human experience requires a means of getting to the essence of the situation, to "*go back to the things themselves"* (p. xxii).

Husserl's phenomenology sought to focus on the consciousness of the experience, a concept he termed '*intentionality*', and this refers to being intentionally conscious of something, a focus on an object or experience (Husserl, 1900/01). However, he was concerned that the 'things' (experiences) became

unconsciously taken for granted in the everyday world of a person due to the individual adopting an uncritical and unreflective attitude towards life experiences, which he termed the '*natural attitude*' (Husserl, 1931). By moving out of one's natural attitude, through the adaptation of a '*phenomenological attitude*', Husserl suggests that the experience can be examined in a more deliberate and conscious way through the *'epoché'* (or bracketing) of pre-conceived views, theories or experiences. This process of phenomenological reduction intends to take the researcher or inquirer closer to the essence of the experience of the phenomenon in order to experience it purely as experienced and given thus resulting in a description of the experience but without any attempt to derive meaning or explanation (Giorgi, 1997).

The Husserlian stance strives to achieve an objective discovery of knowledge, arguably aligning this to the natural empirical scientific approach he sought to challenge (Burns and Peacock, 2019). Descriptive phenomenology continues to be a valid method, notably promoted through the work of Giorgi (1997; 2010) who argues the need to ensure a scientific status is continually applied to pure phenomenological research through the transcendental process of the phenomenological attitude. However, the need to bracket the natural attitude to transcend and step outside of oneself to get to the pure essence of the experience was contended as the phenomenological movement was further developed, notably by Martin Heidegger.

Heidegger (1927) contended that consciousness could not be separated from the wider human existence, and whilst he still was concerned with the '*lifeworld*' of the individual (as introduced by Husserl), he sought to focus on the *Being* of human experience in this world, a concept he termed '*Dasein'.* Rather than describing a world separate from the context of the experience, he suggests that the self and the world an individual exists in are intertwined and interconnected. Dasein, or 'being in the world' therefore locates the individual in their own world with context, for example their culture, history, relationships and values (Burns and Peacock, 2019), and as such it is necessary to understand the context of the person having the experience and therefore how they themselves see their world. Heidegger considers time (temporality) and space (spatiality) as key concepts within Dasein. He asserts that an individual's experience is situated with the temporality of Dasein (human existence), and as such the context and interpretation of the experience results as an accumulation of prior and current events, beliefs and understanding, and expectations of what could be in the future (Heidegger, 1927). Spatiality relates to the 'being in the world' element of existence, and how the individual situates themselves in their world, in other words their sense of place in their lived world (Eatough and Smith, 2017; Heidegger,

1927). Consideration of the individual Dasein, and the concepts of time and space was deemed essential to ensure the unique and personal experiences were captured in my research.

Hermeneutics

Hermeneutics originated from the interpretation of biblical and historical texts (Eatough and Smith, 2017). The philosophy of interpretation was separate originally from the philosophy of phenomenology but later incorporated into the theoretical development work of the interpretative phenomenologists such as Heidegger and Gadamer (Smith et al., 2022). Heidegger, a former student of Husserl, moved away from Husserl's epistemological approach of studying the theory of knowledge and argued that an ontological approach to study the science of being and what it means to exist was needed (Pietkiewicz and Smith, 2014; Reiners, 2012). Through his seminal work *Being and Time* he asserted that knowledge about the human experience requires interpretation and as such it was not possible to achieve this with pure description or observation (Heidegger, 1927). Rejecting Husserl's position that the individual can be separated from the object or phenomenon, Heidegger (1927) disagreed that the essences of phenomena can only be discovered if unaffected or unchanged by the individual and argued against the need to undertake phenomenological reduction to create this separation or objectivity (Burns and Peacock, 2019).

Heidegger proposed that everyone derives significance from experience and so exists hermeneutically (Heidegger, 1927). He argued that awareness of the phenomenon is an essential element to hermeneutics thereby asserting that having 'fore-structure' (also known as fore-conceptions), which consist of prior understanding, experiences, knowledge and assumptions, is a necessity to provide interpretation of the meaning of Being (in the world) (Heidegger, 1927). Heidegger (1927) acknowledges that the interpretation of the 'thing itself' should not be obstructed by the presence of fore-structure, but rather that understanding of someone's fore-structure may emerge during the interpretative process. Hermeneutic inquiry expects a back and forth movement of questioning and examining (or re-examining) of the data or text of interest (Horrigan-Kelly et al., 2016). Known as the hermeneutic circle, this is a dynamic process of moving between the whole and the parts of a subject or phenomenon, for example the sentence (whole) and the single word (part) (Smith et al., 2022). This allows the deconstruction and reconstruction of understanding between the participants experience and the researcher as the interpreter (Burns and Peacock, 2019). Thus, the interpretative phenomenological stance can be explained as the process of continuous movement between the phenomenon (lived experience) and the researcher's fore-structures for interpretation and understanding to be achieved.

Idiography

The third element of IPA is idiography which concerns itself with the particular and detailed analysis of the phenomenon as experienced by each person in their own particular context (Tuffour, 2017). This means that participants may experience the same phenomenon in a similar manner but may view or interpret this in different ways. IPA seeks to focus on the uniqueness of the individual's lived experience and to ensure this remains clear (Smith, 2017). Through concentrating on each case separately, the detail of the experience is valued as it is revealed through the interpretative and analytical process (Tuffour, 2017). This ensures that each case is interpreted on its own merit prior to the next case being explored, thereby ensuring an individual experience is fully situated within the context and particular position of that individual's world. Idiography underlines the importance of the individual experience in particular but does not remove the opportunity for identification of similarities (convergence) or divergence between individuals experiencing the same phenomenon which can occur once the individual cases have been fully explored (Tuffour, 2017). The aim of this is not to make generalisations through the aggregation data as nomothetic studies seek to achieve, but rather to explore the variations between the experiences to seek further understanding of what might contribute to the accounts being described (Shinebourne, 2011). IPA allows for the movement from single case to cross case examination and interpretation within its structured analytical framework which will be discussed later (Smith et al., 2022).

Justification for Interpretative Phenomenological Analysis for this research

Acknowledging the appropriateness of a phenomenological methodology, Interpretative Phenomenological Analysis (IPA) offered both a philosophical as well as a practical approach to the exploration and understanding of the phenomenon of interest.

The scoping review uncovered a variety of qualitative studies related to advanced practice, role transition and professional identity but these all utilised methodological approaches which contrast with the aims of this study. This research seeks to understand what the participants experience when they transition into the ACCP role, in other words what it *feels like* and *why.* The principle of a phenomenological methodology to explore the lived experiences of the participants undergoing the phenomenon of transitioning into an ACCP role was suitable and reflective of the ontological and epistemological stance discussed previously.

Acknowledging the appropriateness of an interpretative phenomenological approach, Interpretative Phenomenological Analysis (IPA) was found to offer a structured and experiential approach to

examining and analysing the lived experience of the participants, with the goal of understanding how they themselves makes sense of their experiences (Smith and Nizza, 2022). IPA draws on phenomenology (to explore the lived experience of the participant nurses) and hermeneutic (interpretative) approaches (to make sense of their experiences and the meaning of these to the participants) whilst applying an idiographic stance (focusing on the particular and individual case study of the experience within the context of that individuals lifeworld) (Eatough and Smith, 2017). In other words, it is committed to understand the *specific account of how **a** person in **a** context makes sense of **a** phenomenon at **a** point in time*. This makes it appropriate to study the experience of nurses who have moved from a distinct senior nurse role into an ACCP role as individual practitioners as they would be able to tell their own individual story which is unique to them.

Consideration of the research question and aims confirmed that the purpose was to not only describe the experience but to instead to gain an understanding through the hermeneutical element of IPA. The participants in my study have been immersed in their transition into the ACCP role and adopting an interpretative approach allowed a more contextual and deeper exploration and appreciation of the individuals within their lived world. This acknowledges the influence of social, cultural and other contextual factors of their experience and as such resonates as more in line with my research question and aims of the study. Basing the research purely within a Husserlian tradition would provide description of the phenomenon, and would require personal assumptions to be bracketed and set aside (Husserl, 1913). This was deemed to be challenging given the professional and experiential experience I have in the field of critical care. In addition, the focus in descriptive phenomenology is to discover the essence(s) of the phenomenon or 'the things themselves', with emphasis on the 'what' is being experienced (Sloan and Bowe, 2014) which is partly aligned to the research question but does not fully allow for understanding the meaning of the experience for the individual.

Adopting an interpretative phenomenological approach allowed the discovery of the meaning of the phenomenon from the participants' perspective, blended with the researcher's interpretation through using the hermeneutic method to make meaning of the experience (Matua and Van Der Wal, 2015). As a researcher utilising interpretative phenomenology, it was not necessary to aim for complete bracketing of my previous knowledge or experience, but it was crucial to be aware of these and to be open and transparent through reflexivity to ensure the research was unbiased and honest in its representation of the participants data.

Interpretation was inductive as it arises from the data and not taken from existing theory. Smith et al. (2022) reinforce the importance of interpretation within IPA through acknowledging that both participant and researcher are trying to make sense of the experience, which he terms the double hermeneutic. This dual process concerns the researcher making sense of the participants who are making sense of their experience or phenomenon, and combines an empathetic hermeneutic in which the researcher seeks the insider (emic) perspective of what the participant sees or experiences, with a questioning hermeneutic whereby the researcher looks at the participant account from a different external (etic) position or angle (Horrigan-Kelly et al., 2016; Smith et al., 2022). IPA requires the researcher to adopt both stances of the double hermeneutic in order to understand what the experience is like and the meaning of this to the participant, and to understand through analysing, making sense and exploring the meaning in order to report it (Smith et al., 2022).

Finally, the idiographic element allowed the research to move beyond the consideration of the data but to also appreciate the individuality and context of the participants and their experience. The Heideggarian concept of Dasein promotes the idea that each of the participants are unique whilst sharing experience of the phenomenon of interest (Heidegger, 1927) which was central to the aim of this study in order to ensure individuals' experiences, thoughts and perceptions were explored and preserved, whilst possibly contributing to a wider collective interpretation of the phenomenon of interest. Participants may experience a phenomenon in a similar way but may view or interpret these in different ways due to various personal, interpersonal and social or cultural factors. Consequently, this study sought to make meaning of the personal journey of the individuals to gain understanding of how they construct their new professional selves and the factors that have influenced this transition and change.

IPA requires the use of critical questions to explore the participants perspective, thus the researcher will explore their accounts, providing interpretation which can be seen as partially subjective and speculative (Miller et al., 2018). This places emphasis on the importance of reflexivity and awareness of the researcher about the choices and interpretations they undertake during the research process which may be influenced through existing fore-structures (Engward and Goldspink, 2020; McIntosh, 2023). This will be considered more explicitly in the following chapter.

Chapter summary

In this chapter, I have set out my ontological and epistemological positioning, justifying an interpretivist approach for this research. Following consideration and evaluation of other qualitative research

approaches, Interpretative Phenomenological Analysis has been selected for this study. IPA has been presented and justified as the most appropriate methodology to underpin the strategy to answer the research question concerning the lived experience of critical care nurses transitioning into an ACCP role. The next chapter will set out the methods used during the empirical investigation.

Chapter 5 Methods

Introduction

Following the establishment of IPA as the methodology of choice for this study, this chapter will examine the methods utilised to generate data to answer the research question and aims for this study. The chapter will commence with reference to key ethical principles that as a researcher I was aware of. The identification and approach to access participants will be explained, by describing the sampling strategy and recruitment process. The methods used to conduct data collection via interviews and subsequent data management will be justified. Explicit ethical considerations to ensure participant well-being and data protection will be explained. Finally, the issues relating to research rigour and quality assurance will be considered. Personal reflections throughout the research planning and implementation stages have helped me to explore and understand the decisions taken, and so reflexive excerpts will be provided within this chapter to further illustrate integrity and transparency during this research process.

The process for data analysis is guided in line with criteria stipulated for IPA research (Smith et al., 2022). As this stage was complex and significant in moving the data from a descriptive stage to one of interpretative insights, the analysis process will be presented in detail in Chapter 6, with the presentation of findings being offered in Chapter 7 and 8.

Ethical considerations

Prior to conducting any active elements of the research process, specifically participant recruitment and data collection, ethical approval was applied for and gained from Birmingham City University's Faculty Academic Ethics Committee (FAEC) (Appendix 2). Undertaking an ethical approval process ensured the proposed study was scrutinised to confirm that it was designed in a way that ensured the protection and maintained the welfare of the participants. It was also important that I was able to distinguish the explicit need for this research, including the stipulation of proposed benefits that the research will generate. This could be viewed as the first and most important ethical consideration, to prevent unnecessary research from being undertaken. Completion of a robust scoping review which confirmed a need for this study supported the justification for proceeding to the practical stage of the research.

It is important to acknowledge at this stage that research ethics is a broad concept and should not be viewed merely as a procedural expectation that has to be gained as part of the quality assurance process of undertaking research with participants (Willig and Stainton-Rogers, 2017). Guillemin and Gillam (2004) suggest that as well as procedural ethics, there is another dimension of 'ethics in practice', which requires the researcher to be aware and responsive to ethical issues that may arise during the

conduction of the research process with participants (Moriña, 2021). In particular, it is essential to carefully consider sound ethical conduct within qualitative research due to the interactive nature between the researcher and the participants (Holloway and Galvin, 2017). Whilst the broad ethical principles of *autonomy* (the right to self-determination and making own decisions)*, beneficence* (to do good, to benefit)*, non-maleficence* (to avoid doing harm) and *justice* (fairness) (Beauchamp and Childress, 2019) remain valid, other authors have examined the specific ethical considerations when undertaking qualitative research.

Bryman (2016: 125) highlights four key ethical principles which more specifically underpin the qualitative research process, these being: "*avoid harm to participants; ensure informed consent of participants; respect the privacy of participants; avoid the use of deception"*. Similarly, Brinkmann and Kvale (2017) address what they describe as the traditional four fields of research ethics that need to be considered and addressed by researchers: *informed consent*, *confidentiality*; *consequences*; and *the role of the researcher*. With many overlapping principles, both frameworks have formed my approach to conducting ethically sound research. Specifically, I have actively addressed participant informed consent, participant privacy, anonymity and confidentiality, data protection and storage, and participant support and well-being. These were carefully considered, removed or mitigated for, and are addressed in more detail throughout this chapter.

Participant sample and recruitment

The primary concern within IPA research is to examine the phenomena of interest intently and deeply, as experienced in the context of an individual's situation. Therefore, a purposive sampling strategy was employed to gain access to a homogenous group of individuals who could offer insight into the phenomena under investigation, allowing access to the experience and meaning of this experience to them, and thereby answer the research question (Smith, 2017). The essential homogenous factor required from the participants was that they were a critical care nurse who had made the choice to transition into an ACCP role, and therefore they would be able to offer a perspective of that experience. The degree of homogeneity sought can vary depending on the nature of the study and availability of the potential sample. In keeping with the key principles of IPA, I determined it not to be necessary to narrow the homogenous criteria as the study aim was to discover a deep and rich exploration of the unique personal experience of each participant in a meaningful way, providing an idiographic approach rather than a need to understand a wider population. It is important to remind the reader that IPA does not seek to create a theory or produce generalisable data but seeks to allow the reader to evaluate and draw their own conclusions about the transferability to other contexts or situations (Smith et al., 2022).

Inclusion and exclusion criteria

To ensure the suitability of potential participants to contribute to the study, key eligibility criteria was outlined and stipulated in the recruitment documents (See Table 11).

Table 11: Participant inclusion and exclusion criteria

Inclusion criteria	Exclusion criteria
Registered nurse who has completed an ACCP course and qualification.	Trainee ACCP's, nurses considering applying to become a trainee ACCP, or qualified ACCPs who are not registered nurses.
Participants must have been in a substantive ACCP role in critical care for at least 6 months since completing the course.	Other advanced practitioners working in critical care but are not a qualified ACCP.
Participants must be in clinical practice in their role currently.	Participants who are ACCP's but are not currently in clinical practice (for example if they are on parental leave or long-term sick leave.

As discussed in Chapter 2, the ACCP role is underpinned by a distinct qualification and standard for practice (Faculty of Intensive Care Medicine, 2015) and so participants were required to have completed their course and be in their substantive ACCP role for at least six months. The rationale for this is that trainee advanced practitioners who have not fully completed a process of academic and experiential learning will still be transitioning and as such they may not have an established sense of their role, professional identity, or positionality. I recognised that very recently qualified ACCPs (within 6 months) may also not be fully grounded within their role and so may have a limited lived experience of working substantively in their new professional space, and for that reason they would also not be recruited. In contrast, as the ACCP role has been established since 2008 (Faculty of Intensive Care Medicine, 2015) it was possible that some practitioners would have extensive experience within the role and consideration was given as to the potential advantages or disadvantages of including these individuals within the recruitment process. In particular, as the length of time within the role could vary from a few months to up to 15 years, attention was given as to whether this could compound the potential for cross case analysis to determine divergence and convergence generated during the 7th stage of data analysis (Smith et al., 2022). However, IPA is primarily concerned with the individual experience in line with its idiographical approach and so there is justification for including any ACCP who fit the inclusion criteria, as every case is of value in its own right. A further consideration was given to potential participants who may not currently be in clinical practice. I decided to exclude these individuals as their experiences may not reflect the current and contextual situation of their lived world which is key in IPA (Smith et al.,

2022). Exclusion would also ensure protection of those individuals who may be isolated from their professional support networks.

Participant recruitment

Several strategies were employed to recruit participants involving a range of networking activities aimed to promote participants self-selected themselves for the study. As my target participants were all ACCPs working in critical / intensive care environments, I was very aware of the potential challenges of accessing healthcare environments following the global COVID-19 pandemic, with visiting practices still being carefully managed at the time (Spring 2022) (NHS England, 2022). Ethical approval would also be required from each NHS organisation that I wanted to collect data in. This would be challenging to predict as I would not know where my participants worked. I did not view this approach to my recruitment strategy as a limitation. On the contrary, I was keen to not recruit just from my local region, but instead to recruit nationally which could provide a wider representation of the lived experiences of ACCPs across the country. To facilitate recruitment, I sought advice from the National Association of Advanced Critical Care Practitioners (NaACCP). This organisation was founded in 2013 and aims to be a forum to provide advice, resources and be a point of contact regarding issues concerning ACCP practice. From this group, there are nine regional network groups including one for Scotland and one for Wales. Following ethical approval, contact was made with the Chair and Secretary to provide an overview of the research aims and to request 'Permission of Access', in essence that they would support me by forwarding information about the study to the wider membership of the group. Whilst I received a positive response, I was unable to gain formal confirmation that the information had been distributed.

I also decided to seek the opportunity to recruit via my established professional social media presence (Twitter® - now referred to as X), as I already had access to relevant professionals and associated organisations via their own accounts (followers and following). Promotion of my study was undertaken in March 2022 in the form of an advertisement-style tweet requesting interested practitioners to contact me via email for further information (Appendix 3). The snowballing effect of using social media gained a lot of expressions of interest or promotion of my advert to others within the network, although conversion of interest into consented participants was slow. The use of social media platforms to reach a wider range of potential participants is advantageous as it can reduce or remove barriers such as geographical reach, cost, and lack of diversity of possible participants (Sibona et al., 2020). I was also aware that some potential participants may not have an online presence on the Twitter platform, and so may not have been aware of the study, possibly introducing a bias to the sampling strategy (Leighton et al., 2021). Referring to the idiographic and individual focus of IPA, I was not concerned that the

recruitment strategy would have a detrimental impact on my final participants, as they would all be valued for bringing their unique lived experience to the research.

Careful consideration to the target sample size was required. A target sample size of up to 6-8 participants was initially identified. The primary concern of IPA is that it allows fewer participants to be examined in greater depth as unique case studies, rather than a seeking a greater number of participants but not being able to examine these to a satisfactory depth (Hefferon and Gil-Rodriguez, 2011). Subsequently, the sample size for IPA studies needs to allow for sufficient data generation to ensure analysis and interpretative meaning can occur, but not too large that it generates an excessive volume of data (Smith et al., 2022). It is important to remember that IPA does not seek to generate theories such as within ground theory (Charmaz, 2014) nor is its aim to generate data which is generalisable to a wider population (Peat et al., 2018). Therefore, it was important to resist the notion that larger numbers of participants provide better data or convey a higher level of quality. There is no specific guidance regarding specific sample size, and even a single case study is advocated as potentially powerful, however it is recommended that between 6-10 participants for doctoral level studies is appropriate (Smith et al., 2022).

The initial advert resulted in the recruitment of four participants who were subsequently interviewed, so the advert was re-tweeted (re-distributed) which gained an additional two participants. I considered whether six participants were sufficient to provide rich data in relation to the phenomenon being studied, particularly as I had not commenced data analysis at this point. After reflection and deliberation with my supervisors, I decided to advertise once more to try to gain one or two additional participants, but if this did not occur then it was acceptable for six cases to still be in line with the tenets of IPA (Smith et al., 2022). The advert drew one further participant into the study. Incidentally, at that time I attended an advanced practice conference event, and during a chance conversation with someone about my research, they confirmed that they were a qualified ACCP and they asked if they could participate in the study. The final sample of eight participants selected themselves on the basis of meeting the inclusion and exclusion criteria, and that they consented and proceeded to the data collection stage. All had undertaken a form of master's level qualification to support their transition into the ACCP role, either to post-graduate diploma or full MSc level. The participants originated from a range of geographical areas including England, Scotland and Wales, although these locations have not been attributed to the individuals to promote anonymity. Consequently, the representation of this sample in terms of their gender, ethnicity, age, or other parameters is not of direct concern for this study, nor is this study

claiming that they are representative of the wider ACCP population. Table 12 provides an overview of the participant characteristics. The participants will be introduced in more detail in Chapter 7.

Table 12: Participant characteristics

Pseudonym	Year of nursing qualification (as per NMC register)	Registered nurse experience prior to commencing ACCP training	Length of qualified ACCP role	Undertook ACCP training in same organisation as where they worked previously as a critical care nurse?	Currently working as an ACCP in same place they worked as a critical care nurse?	ACCP experience in another organisation?
Anna	1994	24 years – mostly critical care	10 months	Yes	Yes	No
Alex	2001	15 years – mostly critical care	4 years	No	Yes	Yes
Victoria	2004	14 years – approx. 9 years in critical care	18 months	Yes	Yes	No
Frances	2006	13 years – mostly critical care	3 ½ years	Yes	Yes	No
David	1993	16 years – mostly critical care	11 years	Yes	Yes	No
Isobel	2005	9 years – approx. 4-5 years in critical care	6 years	Yes	No	Yes
Matthew	1995	17 years – mostly critical care	9 years	Yes	Yes	No
Emily	1995	20 years – mostly critical care, but approx. 3 years in other areas/ roles	6 yrs	No	No	Yes

Ensuring informed consent of participants

Informed consent aligns to the broader ethical principle of autonomy and concerns itself with ensuring the participant has received sufficient unambiguous information about the research project, including any potential risks, in order for them to decide whether they want to be involved (Gerrish and Lathlean, 2015). A Participant Information Sheet (PIS) was provided to potential participants, which clearly set out the purpose and process of the research study (Appendix 4). Information was provided about what would be expected from them in relation to the topic of the interview, and the need for them to be able to offer the time to undertake this. It also explained the voluntary nature of their consent and provided assurance of their rights, such as the right to withdraw from the study without consequence. Once the individual was happy to participate, a consent form was provided for the participants to complete and return prior to the interview taking place (Appendix 5). Completed consent forms were stored in my secure PhD student OneDrive folder to comply with university ethical guidelines. Consent was also re-

checked at the beginning of each participant's interview, to verify they still were happy to proceed, and all participants confirmed their consent. Despite this, it was important to ensure they maintained their right to self-determine their ongoing agreement for their data to be collected, and so at the end of the interview they were reassured again of their right to withdraw within the four weeks following the interview. This time limit was selected to allow the participant to withdraw consent prior to when full interview transcription and data analysis would need to begin, and this was made clear to the participants within the PIS and consent documents as well as at the interview to ensure honesty and transparency (Smith et al., 2022). None of the eight interviewed participants requested to withdraw from the research at any point.

Ensuring confidentiality and anonymity

All participants were assured that their personal data and identification would be treated in confidence during and beyond the process of the research study and this was addressed within the PIS and consent forms, as well as verbally reiterated at the beginning of each interview. It was necessary to demonstrate to the Faculty Academic Ethics Committee that all data gained from participants would be managed in accordance with the General Data Protection Regulations as outlined in the Data Protection Act (2018) and within the framework of BCU's Research Integrity standards which includes more recent guidance, 'Research Data Management while working from home (V1.1 – 29/9/20) (Birmingham City University, 2020a), and 'Using MS Teams for online research data collection (V1.0 – 28/9/20) (Birmingham City University, 2020b). Each participant was allocated a unique participant identification number (PIN), for example, P1, P2, as soon as consent was given, and subsequently all documents related to the participants, including the MS Teams video of the interviews, only had reference to their individual PIN and not their real identity. All documents and other files were saved within my secure PhD student OneDrive folder.

Confidentiality requires that data is not revealed to a third party (Willig, 2022). However, the nature of qualitative research and in particular IPA, which generally has fewer participants and provides rich descriptive data, is that the words and thoughts of the participants are explicitly presented so arguably true confidentiality is not achievable (Holloway and Galvin, 2017; Smith et al., 2022). Instead, it was essential to ensure transparency about what would happen with the data and how the participant's anonymity would be protected. All participants were assigned pseudonyms, which only I could attribute back to a particular participant. The use of pseudonyms, rather than P1 or Participant 1 was important to ensure I maintained a personal connection to each of the individuals lived experience shared with me during this study. It also humanises the representation of their stories to the reader and supports a level

of familiarity as each individual is re-referred to by a name throughout the thesis, thus reflecting the idiopathic nature of IPA (Smith et al., 2022). I had not given the decision of choosing pseudonyms much thought other than I recognised this was an important part of ensuring the privacy of the participants. There may be challenges and pitfalls for researchers who use pseudonyms in an automatic and standardised way, and researchers should consider how they select pseudonyms with sensitivity to cultural, gender and identity, social and age-related factors (Lahman et al., 2022). However, there are tensions in choosing a name to reflect these contexts whilst not inadvertently providing some detail about the person that could be recognised.

Excerpt from reflexive journal:

On reflection, I realised that for simple demographical information, I have identified my participants as male, or female based on their name and visual appearance but had not considered asking them. As a researcher concerned with professional identity, I seem to have ignored their personal identity. Allocating a pseudonym can be viewed as a privilege but is also one which imparts a degree of power and impact. How would I choose a name for a participant from another culture or ethnicity, and know it was an acceptable name? How would I choose a name for someone of a different generation, who could be offended if they perceive the pseudonym to be too young or too old for them?
I became aware that my participants may read about themselves if (when) I publish this research and may not be happy to be 'known' as that pseudonym. To address this, I need to actively consider my decisions on allocating pseudonyms, acknowledging any biases or assumptions that I may have about the participants, and show transparency about the naming decisions I take.

An option I had not considered was to offer the participants the opportunity to choose their own pseudonym, although this could pose a risk if real names, comedy names or duplicate names were selected (Wiles, 2013). My pragmatic approach for allocating pseudonyms was to select names that I personally had no conflicting associations with (so no names of immediate family or friends). Another consideration is that IPA seeks examples of the participants lived world through the provision of verbatim quotes. Therefore, I also recognised the need to ensure other potentially identifiable factors, such as employing NHS Trust, place of study, or geographical location would be redacted from the interview transcripts and not used explicitly within any exemplars included in this thesis.

Data collection

Using semi-structured interviews

The core premise of IPA is getting to a rich, detailed first-person account of the experience or phenomenon of interest (Smith et al., 2022), in this study that is the lived experience of their transition

from a nurse role to an ACCP role. This requires a conversation, or interaction with the participant as a direct way of getting to know and understand their world (Brinkmann and Kvale, 2018). Interviews, or more specifically individual semi-structured interviews are the preferred method of data collection for IPA studies (Peat et al., 2018; Smith et al., 2022), although other methods such as reflective diaries and focus groups have been employed to collect data by some researchers (Naylor et al., 2016; Pietkiewicz and Smith, 2014; Thompson et al., 2022). Focus groups are useful to explore a social or inter-relational exploration of a subject or topic, but can be criticized for their potential to facilitate certain participants to dominate the discussion, which potentially risks the exclusion of others (Holloway and Galvin, 2017). This can be viewed as incongruent with the more personal, idiographic interpretation of the meaning of the experience, and can present challenges in data analysis compared to data gained in a one to one context (Smith et al., 2022). It was also an impractical approach for data collection due to the geographical spread of the participants.

Developing the interview questions and guide

The overall aim of the interview was to get the participants talking about their experience about their transition into an ACCP role, placing them as the experiential expert (Smith and Osborn, 2015). An interview schedule, developed from the research question and literature review, provided a guide and framework for the interviews (Appendix 6). The schedule evolved from initial topics, such as explaining their current ACCP role, transition experience, professional identity, and relationships with other healthcare professionals, into a selection of open-ended questions, with further refinement of both the wording and the order of questions before the final version was formed.

Within IPA guidance, the type or nature of the question also needs careful consideration (Smith and Nizza, 2022). For example, a descriptive question to elicit a descriptive or factual response was helpful at the beginning of the interview, to relax the participant and to allow them to discuss or describe themselves and their role. Narrative questions, such as Question 3 (‘Can you tell me about your reasons….’) allowed for a broader and more open response, whilst reflective and evaluative questions (for example Question 5) sought to explore their experience and feelings. The use of pre-constructed prompts, used to clarify a question if needed, allowed an opportunity for encouraging further detail to enrich the response (Noon, 2018), whilst emergent probes were used to encourage the participant to elaborate on something they had said (Smith and Nizza, 2022).

Brinkmann and Kvale (2018) describe two metaphors of the interviewer role – the *miner* or the *traveller* - which offer differing epistemological approaches to the collection and construction of knowledge. The

miner seeks to uncover hidden nuggets of knowledge, typically objective facts or core meanings often but not exclusively associated with the positivist paradigm. In contrast the traveller typifies the interviewer as being on a journey of discovery, wandering via the conversation process with the individual to discover and unfold the nature of knowledge through their experience. This approach expects a more reflective stance and openness to new understandings and conceptions. Formulating the interview schedule provided sufficient structure and direction for discovering the lived experiences of the participants but also allowed an opportunity to explore emerging avenues opened up by an individual participant, reflecting the traveller metaphor. Completion of the schedule was reached with a recognition that I was very nearly at the data collection stage of my research, as commented in my reflexive diary:

Excerpt from reflexive journal:

Having a typed interview schedule on which the questions appear to be fantastically clear and well-constructed is one thing. Actually, asking the questions aloud to another person to determine if they do make sense is another thing. I had some degree of apprehension about reaching the recruitment and data collection stage. Up until now, my slightly meandering doctoral journey had been very academic – reading, writing, talking, more reading, etc. All of a sudden, the idea that I would need to interview strangers and not make a complete mess of it felt very daunting.

Testing the interview

A pilot interview with a suitable participant is advised, allowing the interview questions, flow and generation of responses to be tested (Smith and Nizza, 2022). I elected not to wait to use my first participant as there is a risk that if significant changes are made to the data collection tool, the data gained in the pilot may be unusable. Instead, I undertook some practice activities beginning with a relaxed, informal read through of the questions to a trusted colleague who has extensive experience as an advanced practitioner, and so I felt she could position herself as someone who once undertook a transition into her role. Feedback and discussion of this first real-time run through of the questions helped to discover how they felt and sounded by both of us, resulting in a few minor alterations to the phrasing in some parts. I then undertook a more structured 'pilot' interview with a different colleague with whom I have a more distant professional relationship with. She did not fit the demographic of my chosen participant group; however, she was a registered nurse with specialist clinical experience who had transitioned into an academic role. Through changing key words in the interview schedule, such as critical care nurse/ nursing for her previous specialist role, and transition into an ACCP role to transition into an academic role, the interview appeared to flow smoothly overall. Watching the MS Teams video back again allowed for further self-evaluation and reflection on my interview technique. I realised that

I was relying on reading the questions from my schedule, and I could see I kept glancing down to check the schedule at times when she was looking at me. Developing a rapport in semi-structured interviews is essential in promoting an open conversation but can be disrupted if the role of the researcher becomes prominent enough to remind the participant they are being interviewed (Willig, 2022), which appeared to happen as I was being distracted with my schedule. I also realised that some of my questions were leading, and on occasions I appear to interrupt her, albeit this was not intentional. The practice interview was also helpful from a practical perspective, as I considered in my reflexive diary:

Excerpt from reflexive journal:

I am familiar with using MS Teams as a tool, but I do not really scrutinise myself using it. Taking the opportunity to watch the interview, I was conscious that I kept looking away from the screen. I think I was checking my notes to see if the interview was still on track. I did not think at the time that it was important but watching back, I can see her expression changing as she noticed I was not still looking at her. I could see there was some glare and reflection on the screen which I need to address in my main interviews. I also noted that I said 'ermmm' a lot! I am very conscious of trying to avoid this when I undertake the participant interviews.
This pilot interview was very helpful as I got to practice with my transcription tool (o-Transcribe), and to appreciate the work involved – this was a 26-minute recording and took just over 2 hours to transcribe it. I also need to allow the time to re-listen and check the accuracy of the transcriptions and add in any non-verbal or other cues of interest.

Following the pilot interview, minor revisions were made to the interview schedule to ensure the questions and prompts were clearer in their meaning. Undertaking a practice interview helped me to appreciate the skills needed to conduct good quality participant interviews. Being fully familiar with my schedule ensured I was engaged and flexible during the data collection stages.

The interview process

Participants who consented to proceed were invited to arrange a mutually agreeable date and time for the data collection interview. All eight interviews were conducted between May 2022 and April 2023, reflecting the stages of advertising and recruitment explained earlier. The interviews were undertaken via MS Teams, which was a deliberate decision made at the early planning stage of the study as previously explained. The increased use of video conferencing processes (such as Zoom or Microsoft Teams) employed in response to the COVID-19 pandemic provide a more suitable method of interviewing, offering advantages such as better accessibility to the participants, reduction in resources (such as time and costs of travel), and reduction in risks to the interviewer (Gray et al., 2020). I also hoped that the participants would feel more empowered and relaxed if they were in a chosen environment at a time to suit themselves. Ethical approval conditions precluded any form of data

collection on NHS organisations' premises, which avoided the challenges for the participant to find protected and undisturbed time within their working day. As the participants would be interviewed in their own time, I was aware of the importance to offer full flexibility to the participants to include early or later in the day times, or weekend interviews if that were more convenient. One participant did request a weekend interview initially, although later this had to be rearranged at their request. Online interviews are not without potential challenges, such as ensuring the participants have access to devices to facilitate a live MS Teams meeting, or technological issues on the day (such as loss of Wi-Fi connectivity) (Cohen et al., 2018). Participants were aware that the interviews would be via this platform as it was stated on the advertisement and the PIS, and further guidance was offered if required. There were no specific problems concerning the use of MS Teams during any of the interviews, and the only interruptions encountered were as a result of two participants needing to respond to their doorbell, although these were short breaks in the interview and not significantly impactful. Another criticism of using video meeting platforms is the loss of being able to fully see and appreciate the non-verbal cues or body language (Flick, 2022), although I did not feel this was an issue as I could see the upper part of the participant clearly. Notes taken at the time captured particular moments that I became aware of during the interviews, such as hand gestures, movements, and facial expressions.

Time was taken at the beginning of each interview to establish rapport and trust with the participant, and to create a warm and comfortable online environment, which would be essential for obtaining good data (Willig, 2022). After a welcome and confirmation of our names, I would often initiate a light conversation with no relation to the interview (such as discussing the weather or current events), prior to introducing the purpose and process of the interview, and confirming their consent again. Participants were assured at the beginning of the interview that I was interested in their own experience and story, and that I was not looking for any specific answers or information. This was done to reduce any sense of concern that they may not be saying the right thing, and to help them get used to talking about themselves and their experiences. Once the interview commenced, the first broad question invited them to describe their current ACCP role, a question intended to allow them to control the content of the discussion at an early stage (Smith et al., 2022). The prepared interview guide remained a framework for me to come back to if required, but I was mindful from the practice interview that I needed to be actively listening to, and co-participating in the interview with the participant, and so as my confidence and experience grew, my reliance on the guide reduced. This meant that I could ensure that questions relating to the core topics in the guide were asked whilst allowing the participants to take the lead in discussing what they wanted to. In order not to miss something that warranted a deeper exploration, key words, or phrases that I heard were noted down during the interview, and as

appropriate I used prompts or probes to elicit further detail. An example of how an interview explored an emerging part of the conversation is shown below in Figure 5.

Figure 5: Extract from Victoria's interview

Me: I was interested when you were talking about thinking you were not worthy, and how surprised you were, and I wanted to ask about that a little bit more. You must have met the criteria but what was it that made you think that way? Victoria: Probably a good old-fashioned compare and despair, when you think who you are up against so to speak, and the application process. 'Oh, they are much better than me, oh I think they should get'. I was, you know, very self-deprecating probably, yeah definitely a trait of mine. (Lines 138-143)

At times I sought clarity about the use of language or specific phrases used by the participant, to ensure the meaning of these was defined by the participant rather than myself, as my interpretation of the meaning could be significantly different. Figure 6 gives an example of this.

Figure 6: Extract from Alex's interview

Me: I just picked up you said 'right fit' there. What do you mean by right fit? Alex: So, I don't think advanced practice is for everyone. How you work out which peoples it is for is a really interesting thing. (Lines 197 – 199)

This approach positioned me as the 'traveller' who was aiming to enter the world of the participant as they led me through their experiences of transitioning into an ACCP role (Eatough and Smith, 2017). At the end of the interview, I invited the participants to add anything else they wanted to regarding our conversation, before thanking them for their time. I ensured they had information and assurance as to how I would manage their interview data and checked they did not require any specific guidance or support. None of the participants wanted to preview a copy of their interview transcript which I offered to them. Each of the eight interviews lasted from between 51 minutes to 1 hour and 19 minutes.

Consequences and the avoidance of harm

Potential consequences for the participants, particularly in consideration of the ethical principle of non-maleficence, or doing no harm (Beauchamp and Childress, 2019), were considered and where necessary mitigated for. In qualitative research, harm to participants refers to both potential physical and psychological harm that the participant may experience this can occur during or following the data

collection process conducted between the researcher and the participant (Holloway and Galvin, 2017). I did not anticipate any specific physical risks to the participants, or myself, as the interviews were conducted virtually online, meaning no travel was required and the participants were advised to select a location where they would be comfortable.

Psychological harm, including the use of deception, was considered from the perspective of the participants, but can also occur through the misrepresentation of the research data to the wider community (Bryman, 2016). Inadvertent harm or deception of participants was avoided through the robust and transparent ethical approval process and the provision of clear and detailed Participant Information Sheet (PIS) and consent form. This ensured transparency of the purpose and process of the research project, although Flick (2018) highlights the difficulty in identifying how much detail to provide about the proposed research enquiry which will be both sufficient and appropriate. To address this, the PIS document contained an invitation that interested individuals could contact me directly to discuss the process or ask further questions before they decided to consent or not. All email communication prior to the interview was respectful and warm, which helped to establish trust and rapport.

Care was taken to ensure the participant was comfortable in their environment at the beginning and then during the interview, checking that they had things to hand that they may need (i.e., drinks). It was not anticipated that the topics within my interview guide would be provocative, but I did recognise that the interview would be about the participant's own experiences and so could have the potential to elicit feelings, memories or emotions which could be deemed as uncomfortable or harmful for them. Participants were assured that they could take a break, or if there was a particular question or topic they would rather not discuss then that would be respected by the interviewer, and I would move the interview on. The participants were also assured that they could end the interview at any point if they felt they could not or did not want to continue. None of the participants chose to do this but I did remind them that as stated in the PIS, they could contact myself, or my supervisors should they have concerns after the interview, or alternatively I would help them to identify an alternative source of support via their organisation, such as Occupational Health or similar. Potential participants who were not currently in their role (for example if on extended leave) had been excluded from participating, as they may not have had full access to their team or employer's support systems should there be a need for these.

As well as identifying and mitigating potential harm, I also considered the positive consequences and possible benefits for the participants of the research study (Brinkmann and Kvale, 2017). The PIS explained that this research area had not been explored before, and so the knowledge generated could

help future critical care nurses considering a move into an ACCP role. Participants were also made aware that the completed research could be disseminated within critical care or advanced practice forums, contributing to a wider appreciation of the experiences and needs of nurses changing into this role.

Data management

Each of the interview video recordings were downloaded from MS Teams and stored in a University approved OneDrive to ensure compliance with the General Data Protection Regulation and the Data Protection Act (2018), as outlined previously. I personally transcribed each interview shortly afterwards using 'oTranscribe®', a web application with an integrated video player which enabled me to watch and listen to the interview whilst transcribing onto the screen, before exporting the text into a Word document once it was completed. IPA expects a full record of the conversation to be documented verbatim so that interpretation of the meaning of the participants account is possible (Smith et al., 2022). For accuracy and to ensure I did not miss any dialogue from the participant, I checked the full recording and amended the transcripts as necessary. At this stage, I noted down some prosodic and observational elements of the interview such as changes in tone of voice, changes in emotion, or gestures and facial expressions which can be useful in providing context and meaning to what has been said (Willig, 2022). Whilst this was time-consuming, as each transcript took approximately 10 hours to complete, it allowed me to engage with the raw interview data immediately. Through this process, I was able to get closer and more familiar with the voice of the participant and so begin an initial move into the interpretative process (Smith and Nizza, 2022). In readiness for the data analysis stage, each transcript was formatted to include line numbers and wide margins on both sides to facilitate notes. Transcripts were printed and spiral bound to facilitate organisation of the large documents and to ensure they remained intact for the duration of the study. Symbolically, I felt it to be respectful to represent the eight separate participant stories in physical format in this way, valuing and reflecting the idiographic approach of IPA (Smith et al., 2022).

Sound ethical standards were maintained throughout the whole project, considered and discussed within the supervisory process, and evidenced within the presentation of University formal progression reviews updates as required at key stages. These considerations work in parallel with other quality assurance processes to ensure transparency and trustworthiness in the wider research process. The next section will present more detail in regard to how research quality and validity have been addressed.

Research quality and validity

I was cognisant that the nature of qualitative research, and in particular IPA, is subjective and contextual, with the influence and positionality of the researcher firmly situated at the core of each stage of the research process. Consideration was made of potential issues in the earlier development and planning stages and throughout the later data analysis and presentation of results stages. This ensured robust strategies were enacted to promote high quality and validity of the conducted research. I have set out in Chapter 3 the validity, which relates to the extent that the research design and methodology are appropriate to address the research question (Holloway and Galvin, 2017), to provide assurance about the accuracy and usefulness of the data generated.

Frameworks or checklists for determining rigour and quality of qualitative research are useful, particularly for the less experienced researcher but caution is required that these do not lead to a simplistic or mechanistic approach to ensuring a quality research approach (Greenhalgh, 2019; Smith et al., 2022). Smith et al., (2009) promote the criteria developed by Yardley (2000) within the first iteration of the seminal IPA text book. Recognising that these guidelines are generic, and that no standard existed specifically to address the quality of IPA research, Smith (2011a) developed criteria to identify different levels of quality in IPA studies– unacceptable, acceptable and good. The main qualities identified for research papers include *the clear application of the theoretical principles and three tenets of IPA*; *transparency of the research process for the reader*; *analysis that is coherent, plausible and interesting*; and *sufficient sampling to present a density of evidence from the participant extracts in each theme* (Smith, 2011a: 17). This standard was further developed by Nizza et al., (2021), who identify four specific indicators for assessing the quality of IPA research papers, but also to help researchers undertake and present a high quality IPA study themselves. At the onset of the research process, Yardley's (2000) four broad principles for quality - s*ensitivity to context; commitment and rigour; transparency and coherence;* and *impact and importance* – were considered and rigorously applied. Table 13 outlines the strategies employed to ensure these were considered and rigorously applied. The more recent publication of IPA specific quality guidelines (Nizza et al., 2021) was applied to frame the critical evaluation of my completed research, and is presented in more detail in Chapter 10.

Table 13: Strategies for ensuring quality in the study (as per Yardley's (2000) quality principles)

Characteristics of good qualitative research	Strategies applied for ensuring quality principles within this study:
Sensitivity to context	• Completion of a detailed scoping literature review of existing evidence base to develop the research question, to underpin research methodology and method choices. • Sensitivity towards participants – researcher insight and awareness of socio-cultural context of participants and setting (Nurses/ Critical Care/ NHS) • Sensitivity to ensure personal (idiographic) experience of each participant is respected and represented • Ensuring open and non-judgemental approach during data collection process to elicit open and honest account of participants experience and perspective. • Ethical considerations are clearly considered and addressed. • Rigorous data management throughout the study
Commitment and rigour	• Clear engagement with all elements of research process over a prolonged period of time. • Attentiveness to data collection process – through exploring and developing tools and methods to ensure good quality data and good quality participant experience • Adherence to the guidance for data analysis in IPA to ensure the three core elements of IPA are evident, reflecting philosophical and methodological alignment • Active engagement in supervision and reflection; being responsive to feedback and self-identified gaps in research skills or knowledge. • Proactive development of skills and experience to undertake the research (for example attending IPA training and engagement in the IPA professional community).
Transparency and coherence	• All decisions relating to the stages of research process were shared with supervisors and are presented in this thesis for the reader. • Ensuring data is presented clearly using tables, diagrams, appendices as well as within the narrative of the thesis. This evidences how interpretation has been generated, supported with verbatim extracts from transcripts to illustrate meanings. • Clear coherence and application of IPA methodology and method throughout all stages • Clear account of researcher role and position within the research process, for example through reflexivity (researcher diary and other documents), and through supervision discussions • Critical reflection and evaluation of my role as a researcher will be provided
Impact and importance	• Justification of the importance of this research, and consideration of potential benefits to key stakeholders is evident within different parts of the thesis / different stages of the research process. • Clear evidence that I have ensured I have given a voice to these participants • Clear identification of impact and importance following data collection, analysis and presentation of findings will be presented • Recommendations drawn from the study findings are made. This includes recommendations for future research

My role as a researcher

Reflexivity

By its nature, IPA methodology does not allow me, as the researcher, to be an objective and distant creator of knowledge. As an active participant, IPA actively situates the researcher centrally throughout the interpretative and analytical stages of the double hermeneutic, or making sense of the participants making sense of their own experience (Smith et al., 2022). To promote transparency and trustworthiness, it was essential to ensure close consideration and examination of the choices I made during the conduction of the research (Geraldi-Gauci, 2019; Goldspink and Engward, 2019). This was achieved through reflection and reflexivity.

Reflexivity in research is concerned with the careful consideration and evaluation of oneself as part of the process (McIntosh, 2023). Various reflective typologies are present in the literature. Day (2012) suggests reflexivity is required for three key areas relating to the production of knowledge generated through qualitative research – the *thinking* (dilemmas regarding the epistemology of qualitative research); the *doing* (dilemmas within the research relationships); and the *evaluation* (dilemmas relating to the evaluation of the research). Hammersley (2023) suggests three forms of reflexivity – *existential* (the role and position of the researcher); *practical* (the actions, decisions and judgements made during the research); and *reporting* (the clarity and accessibility of clear findings for others). Whilst these provide similar frames for the researcher, I preferred a simpler approach as suggested by Willig (2022), who proposes two types of reflexivity. *Personal* reflexivity is concerned with reflecting on how personal thoughts, values and beliefs have influenced the research, whilst *epistemological* reflexivity encourages the consideration of assumptions and decisions about how the investigation is framed and how the findings are understood (Willig, 2022). Active reflexivity enhances transparency, trustworthiness and rigour, thus complementing Yardley's (2000) quality principles.

Whilst this stance helps to frame how reflexivity is of value, it is important to not distil it into a task to be done, but instead recognise it as a dynamic, complex and essential component throughout the research process, and in particular to ensure the key tenets of IPA remain congruent and recognisable (Engward and Goldspink, 2020). Examples of how I have considered elements of these reflexive foci have been provided within this chapter and will continue in subsequent chapters. I will also provide a more focussed and detailed critical reflection in Chapter 10.

Chapter summary

This chapter has outlined the research design and methods employed to address the research question and aims. Justification for the recruitment of participants who have experienced the phenomenon of interest – transition into an ACCP role – has been provided. Strategies for data collection and data processing demonstrate alignment to the principles of IPA. Finally, measures taken to promote sound ethical research practice, academic and research rigour, and personal reflexivity indicate a robust approach taken to the research process. The process undertaken for data analysis will now be detailed in Chapter 5, followed by the presentation of findings in subsequent chapters.

Chapter 6 Data analysis

Introduction

This chapter will discuss the iterative and inductive process undertaken for data analysis of the eight participant interviews. It is essential to set out the explicit methods and details of how data was elicited and analysed for this study, demonstrating a commitment to the principles of IPA. Data analysis ensured an idiographic focus on each participant's worldview. By staying closely grounded to the participants words and accounts of their experience, the focus remained on their personal meaning-making.

Data analysis strategy

A number of different approaches to data analysis are employed within qualitative research, which include thematic analysis (Braun and Clarke, 2022), grounded theory (Charmaz, 2014) and discourse analysis (Willig, 2022). Taken in isolation, these approaches did not align with the ontological and epistemological position of the research and were therefore not considered. Instead, I approached the analysis of the interview accounts by following the principles of data analysis specifically outlined for IPA research.

A core tenet of the IPA approach to data analysis is to explore and appreciate the worldview of each separate participant, through making sense of how they describe and discuss their *particular* experience in a way that is unique to them (Smith et al., 2022). The commitment to idiography, the individuals' own unique experience, ensures the researcher is continuously trying to interpret and make sense of how the participant is interpreting and making sense of their experience, thus applying the double-hermeneutic circle (Smith, 2019). It is only once analysis has been done for each participant that consideration to similar or contrasting experiences are looked for between the individuals. IPA data analysis therefore requires the researcher to move from description to interpretation, in a process that is both inductive and iterative (Smith and Nizza, 2022). The iterative nature of the analysis process facilitated the revision and modification of some of my earlier interpretative decisions because of continuing reflection and reflexivity, and through critical discussion with supervisors.

Smith et al. (2022) provide a 7-step framework for IPA analysis, which has been updated since the initial iteration in the first edition of their book (Smith et al., 2009). Table 14 presents an overview of the IPA analysis process.

Table 14: IPA 7-stage analysis (Smith et al., 2022)

Step	Description
Step 1	Reading and re-reading
Step 2	Exploratory noting
Step 3	Constructing / formulating experiential statements
Step 4	Searching for connections across experiential statements
Step 5	Naming and organising Personal Experiential Themes (PETs)
Step 6	Moving to the next case
Step 7	Develop Group Experiential Themes (GETs) across the cases

Smith et al. (2022) stress that they do not intend to convey a prescriptive approach but rather a method of developing the skills and confidence to fully engage and interpret the meaning of the experience. However, as an inexperienced IPA researcher, the provision of a step-by-step guide was not only reassuring, but also ensured a systematic approach, thus promoting transparency and an explicit account of the actions taken to derive the findings. To further enhance my understanding and skills, I attended two IPA training workshops in 2022. The first focussed on an introduction to IPA data analysis, followed by an advanced data analysis workshop (Gil-Rodriguez, 2022a).

The commencement of data analysis was a significant milestone for my research:

Excerpt from reflexive journal:

I have been looking forward to starting data analysis for quite some time, but I also have felt daunted by the thought of doing it, so it was convenient for me to put it off whilst I did other work, such as writing up earlier sections. I wanted to be almost selfish and have the analysis just for myself, without the pull (or guilt) that I needed to do something else. I was aware that my first interview had taken place a year ago, and the final one 3 months ago, and I had completed the transcriptions immediately after the interviews. So, for many of them I had almost forgotten what was discussed and so the idea of stepping back into them was exciting. I was also worried about whether there would actually be data to be found in some of the interviews – what if they were too brief? Too superficial? Even too 'boring'?

The process for data analysis will now be detailed below, with reference and examples taken from the analysis of my first participant, Anna's, interview.

Step 1: Reading and re-reading

The first step was to immerse myself with the original interview data, which enabled me to begin to enter the participants world. I had undertaken the process of transcription myself, so I already had a good level of familiarity with the participant's interview. As there had been a gap in time from the transcription phase, I re-engaged with the interview by listening to the recording whilst re-reading the transcript. By repeating this process several times, I noticed that I moved from merely travelling through the interview again to a more slowed down and focused consideration of Anna's experiences. This promoted an increasing familiarity with the data, allowing me to note down initial thoughts or observations of particular interest or prominence, such as intonation or key phrases. It also meant that as I continued to refer to the transcript throughout the data analysis process, the echo of Anna's voice, and that of each subsequent participant, remained with me.

Step 2: Exploratory noting

I had chosen to use a 'hands on' approach to the analysis, keeping the printed transcript at the centre of the process. This facilitated a closer link to the participant and their account of their experience. This stage required a slow, thorough line-by-line engagement with the transcript (Smith et al., 2022; Smith and Nizza, 2022) to discern parts which took my attention. By exploring the data in this way, I was able to start to notice both the content of what was said but also the manner or language used to convey the experience. The space on the right-hand side of the transcript was used to form my exploratory notes, which comprised of three differing components of analysis – descriptive noting (in **red ink**); linguistic noting (in **blue ink**); and conceptual noting (in **green ink**). This will now be explained in more detail, with an example section from the interview provided in Appendix 7.

Descriptive noting

Initial descriptive noting was made on the transcript. The focus of this was to note at face value any content which could include processes, events, explanations, or key words given by the participant, which appear meaningful to them and their experience. Drawing on guidance from Gil-Rodriquez (2022b), I asked myself, '*What is being talked about here?*', '*What experiences are being described by the participant?*', '*What are the key features of those experiences for the participant?*' . With Anna's transcript, the act of noting descriptively initially seemed unnecessary as I could not see how it was contributing to the analysis of her words. However, as I revisited the transcript and re-read the notes made, I found them useful in providing an overarching view of her narrative and my observations as they developed.

Linguistic noting

Linguistic noting is concerned with asking *'How is the participant saying what they are saying?*'(Gil-Rodriguez, 2022b). Specifically, I needed to consider how particular words or phrases were used, the tone of voice, the use of humour and whether this seemed appropriate, or if a change in pronouns was used by the participant. Pauses, hesitations or false starts, as well as any non-verbal elements during the interview were noted, as these could indicate that the participant was hesitant in expressing something, or that they were trying to make meaning of an experience they were recalling. Similarly, the use of metaphors could be considered as a way of allowing the participant to present an experience that may be difficult to convey (Smith and Nizza, 2022). In Anna's interview, I noted that she used several idioms as she discussed her experience, for example '*phone a friend*' (p.24) which related to calling for senior help, and '*pulling your pants up'* (p.13) when discussing a need to get on with things which were challenging. Focussing on these elements allowed for some conceptual analysis to begin, as I considered how the participant was making meaning of their experience through their linguistic patterns.

Conceptual noting

The third conceptual noting stage is a more interpretative and interrogative level to the analysis process (Smith and Nizza, 2022). Typically taking the form of asking questions of the data, I was seeking the underlying meaning of the participants experience, therefore forming tentative understanding about what has been discussed. I was looking for parts of the text that appeared to be significant for the participant, as determined through my interpretation as the researcher. This allowed me to then take account of emerging questions or thoughts I had about the meaning of Anna's words. Table 15 provides an example of an excerpt of Anna's interview with exploratory noting.

Table 15: Example excerpt from Anna's interview with exploratory notes

Transcript excerpt (originally lines 37-48)	Exploratory notes
So …… we absolutely bring this wonderful hybrid that comes together between the two. I'm very **clear** on what I can do clinically and I'm also very clear where my gaps are.	Is she placing ACCPs as on their own? Not in either team? Clear? To whom? Has there been issues for her?
So I can resuscitate a patient who's in front of me, and as you know the definition, I always like to think the definition of an ITU patient is resuscitation always precedes diagnosis. I can resuscitate this ITU patient and then I could still be still scratching my head (hand to head and scratches) and thinking, *Well I don't know what's wrong with them*. And that is when I'm looking to my medics and my junior doctors, especially those who are medically in training, and going "*Well there's nothing wrong respiratory, could be sepsis, could be this*." And they'll say some weird and wonderful, vasculitic blah blah blah. "*Lovely - and that's why you're here*" (laughs).	Recognises she may not know what to do. 'My' – staking her place in that team? Need to belong? Humour/ laughs when recounting the need for help. Is she ok with that? Does she feel outside of the team re her abilities?
So I think you talk about these four pillars, and what advanced practice is, and you do have to practice those four pillars. I think if you say I don't do much of that, I only do some of that (counts off on hands) well, I have to argue that you are not encompassing all of the role, and that can be literally just at the end of the bed, assessing because the nurse has said "I'm worried about this patient".	Reiterating the four pillars (again) Stating her view that four pillars are essential.

During this stage, I became aware that I was entering the hermeneutic circle, moving back and forth between the parts of the transcript that I was noticing and noting about, whilst considering them in context with the 'whole'. I was mindful of the need to remain open to this process, to avoid looking for and noting what I may have expected to find but rather seek out the objects that appear to matter to the participant (Smith et al., 2022). This stage was repeated several more times, and with each re-reading I was able to consider new areas within the data that I had not appreciated before, as well as revisit my earlier notes, thus ensuring an iterative and interpretative approach. Formulation of these exploratory notes reflected my thoughts and responses to the participants account of their experience, providing a wealth of information that related directly to their expressed words and the meaning I had started to take from them. These would form the basis for the next step of analysis.

Step 3: Constructing / formulating experiential statements

In this stage I was required to consider the multiple exploratory notes made on the transcript, applying an analytical approach to capturing these through the formation of experiential statements. At this point, the focus has moved on from the initial noting to a deeper interpretation of the participants words. Experiential statements aim to capture and surmise the meaning of the participants experiences as I have understood and interpreted from the interview text, through the exploratory notes already made on the transcript. During this step, I formulated experiential statements that were particular to a

specific section or passage from Anna's account, whilst I also had an overarching appreciation of the whole interview. Smith et al. (2022) explain that each experiential statement provides a concise phrase or summary which relates to a particular part of the text. This stage therefore seeks to reduce the whole of the text, the transcript and the noting to the prominent interpretative thoughts of the researcher. This is necessary as it reflects immersion into the participants account of their worldview, reflecting the hermeneutic circle whereby the parts are considered and interpreted in relation to the whole, and vice versa (Eatough and Smith, 2017).

Smith et al. (2022) recognise that this stage can cause some discomfort for researchers as there is a sense of distilling the participants story into these relatively short and seemingly disconnected statements. However, they remind the researcher that resulting final analysis will combine both the participants and my own interpretations, which will emerge following the Steps 4 and 5. During this stage, experiential statements were noted in the left-hand border of the transcript, as close as possible to the corresponding section of text that they related to (See Table 16).

Table 16: Example excerpt from Anna's interview with experiential statements

Experiential statements	Transcript excerpt (originally lines 37-48)	Exploratory notes
Being a wonderful hybrid Clear self-awareness of scope of practice and limitations	So …… we absolutely bring this wonderful hybrid that comes together between the two. I'm very **clear** on what I can do clinically and I'm also very clear where my gaps are.	Is she placing ACCPs as on their own? Not in either team? Clear? To whom? Has there been issues for her?
Not afraid to not know Belonging – 'my' team Recognising / referring to the higher knowledge of others	So I can resuscitate a patient who's in front of me, and as you know the definition, I always like to think the definition of an ITU patient is resuscitation always precedes diagnosis. I can resuscitate this ITU patient and then I could still be still scratching my head (hand to head and scratches) and thinking, *Well I don't know what's wrong with them*. And that is when I'm looking to my medics and my junior doctors, especially those who are medically in training, and going "*Well there's nothing wrong respiratory, could be sepsis, could be this*". And they'll say some weird and wonderful, vasculitic blah blah blah. "*Lovely - and that's why you're here*" (laughs).	Recognises she may not know what to do. 'My' – staking her place in that team? Need to belong? Humour/ laughs when recounting the need for help. Is she ok with that? Does she feel outside of the team re her abilities?
Stressing all four pillars as being necessary for practice	So I think you talk about these four pillars, and what advanced practice is, and you do have to practice those four pillars. I think if you say I don't do much of that, I only do some of that (counts off on hands) well, I have to argue that you are not encompassing all of the role, and that can be literally just at the end of the bed, assessing because the nurse has said "I'm worried about this patient".	Reiterating the four pillars (again) Stating her view that four pillars are essential.

To facilitate the next steps in the analysis process, all of the experiential statements were transposed, in the order that they had been documented on the transcript, into a table on a separate Word document, along with the corresponding quote from the interview, and the location (line number) in readiness for the next stage (See Table 17). This provided a useful reference document as well as facilitating a transparent record of the first version of analysis of Anna's interview.

Table 17: Example of experiential statements with quotes from Anna's interview

Experiential statement	**Link to transcript quote**	**Line number(s)**
Awareness of risk of role	*I think it's knowing your boundaries. I think the day I kind of go "oof" on that (holds hands up) is the day I need to quit*	105-106
A long process to become an ACCP	*So I've had a longer journey than most in a bit of an ambulatory way (wavy movement in hands).*	110
Feeling jealous of other trainees' experience	*I was jealous if you like of what they were learning and the experiences they were having*	115-116
Recognising need to revisit previous learning again	*I hadn't been able to practice those skills. So actually I didn't feel credible just to say yeah, I'm going to APL out of that aspect. So I redid my clinical examinations, I hadn't done diagnostics, so I redid my diagnostics.*	117-119
Being clear what boundaries were before her ACCP role	*I wasn't out of my boundaries, as I was a prescriber, so I was able to do that and that's part of my prescribing rights.*	138-139
Wanting to do more for the patients	*And I just thought, you know what this is, a - I want more of this, I can do this*	142

On completing this step of analysis, my experiential statements table contained 132 formulated experiential statements, which could be considered high although no distinct guidance is offered. Smith et al. (2022) advise that this is not an uncommon event for inexperienced IPA researchers, who may have re-presented the data rather than create analytical, interpretative statements, something that I later considered:

Excerpt from reflexive journal:

During step 3 for Anna, noting the experiential statements – I found this difficult as it appeared at times that I was rewording or re-presenting the participants narrative, rather than creating an analytical expression. When I came to put these into a table along with a corresponding section of the interview to later be used to organise the PETs, I found that I had generated 132 ESs with corresponding quotes over twelve pages!! I knew that the next stage would require me to cluster these, and so I printed them off and cut each one up. It took nearly an hour to just cut them up individually. I had a reality check of how big a job this is.

For the following participants, I was more conscious ensuring my experiential statements were reflecting my interpretation and analysis of the participants experience more explicitly. Subsequently, the other participants had between 59-89 statements at this stage of their analysis. With Anna's interview analysis, I decided to proceed with all the experiential statements as I was aware that some of these would be condensed or discarded as I proceeded into the next step of analysis (Smith et al., 2022).

Step 4: Searching for connections across experiential statements

Continuing with the idiographic approach, the analytical process required the consideration of the experiential statements, the 'parts' that I had focussed and extracted as being significant in the previous stage in relation to the 'whole' of the participants experience, with the aim of mapping connections between them. This is done to condense, cluster and refine the experiential statements into smaller groups by seeking the connections between them. At the end of this step, the clusters formed will become the participants Personal Experiential Themes.

This step was undertaken physically, commencing with printing, and cutting up each of the 132 experiential statements from the table generated in Step 3 (Table 17). Once the statements were separated, they were shuffled around to disrupt the original order of these as they had occurred in the interview. Taking them one at a time, I was then able to start to form them into position on a large tabletop according to connections I perceived. Initially a process referred to as *'abstraction'* (Smith et al., 2009) was applied, meaning different experiential statements from different parts of the interview were found to be similar or overlapping, hence they were clustered together. This approach afforded me a 'birds-eye' view over the emerging clusters, and allowed me to visualise how the statements fitted together with similar ones (Smith and Nizza, 2022). Time was taken to reconsider and experiment with

alternative positions for some statements, to examine how relationships between and across clusters formed.

The first process of clustering for Anna's experiential statements resulted in a set of ten major clusters each with a large number of statements within them. A tentative descriptive title was given to each of the ten groups of clustered statements to capture the essence of my first interpretative analysis of Anna's experience (see Table 18).

Table 18: Anna's interview - first analysis cluster titles

First cluster group titles	Number of original experiential statements included (total 132)
1: About what it is/ the essence of the role	16
2: Control, supervision, guidelines	12
3: Stepping into role – the reality and the risk	16
4: Wanting and waiting for the role	11
5: The ACCP role – her perspective	12
6: The ACCP role – what others think	10
7: Empowering and smoothing within the wider team	13
8: The learning journey	18
9: Relationships	16
10: The future for the role	8

At this point, I elected to transfer the cluster headings and the associated experiential statements into MindGenius 20, a mapping tool, and each of the ten groups was allocated a specific colour. It was discernible that a number of statements were similar in their meaning and so these were 'stacked' initially, before '*subsumption*' occurred, whereby the strongest experiential statement to capture the meaning of them all was used to categorise that group. In other parts of the process, a cluster of similar themes underwent a re-phrasing of a statement so it embodied the meaning of the group more clearly (Smith and Nizza, 2022). These processes helped to reduce the number of experiential statements whilst maintaining the essence of the interpretation they had been drawn from. As well as similarities, it was also important to be open to noticing contradictions, or *'polarisation'* (Smith et al., 2022). An example of this was found in the following experiential statements from Anna's interview which show conflicting perspectives about how she considers her role and identity (Table 19).

Table 19: Example contradictions from Anna's interview

Experiential statement	*Quotes*	Line
Being a gap filler	*yes part of it is filling a medical gap*	54
Being part of the medical workforce – managing patients as they would	*So yes, we are part of the medical workforce, we are supporting that medical workforce. So we will manage patients as medics would.*	15-17
Clearly does not think she is a medic	*We are very much heavily told you are medics so think medics. I am not a medic (shaking her head). There is nothing in FICM, nothing in the ACCP world that says that I have to say that.*	406-408

During this process, the original transcript was regularly checked to ensure the essence of the 'parts' being clustered still resonated with the sense of the 'whole' of the interview, ensuring that the meaning I was making stayed true to the original data. By being able to move the colour coded statements around, I was able to see how concepts from my first table-top activity had been re-considered as a deeper level of analysis occurred with the data. Working in an iterative manner to cluster and find patterns within the data, and through repeating the process several times over a number of days, the emergence of core themes created by my interpretative actions began to emerge.

Step 5: Naming and organising Personal Experiential Themes (PETS)

Once I reached the point of being satisfied with the clustering of the experiential statements, and the meaning and patterns within them, each cluster was determined to constitute a Personal Experiential Theme (PET). Reflecting a change in terminology introduced in 2022 (Smith et al., 2022), *Personal* reflects the individualised or idiographic case-level analysis from which the themes derive from, *Experiential* relating to the sense-making of their own particular experience, with *Themes* reflecting the analytical process being applied to the whole, not just separate parts of the transcript. At this stage, a title reflecting the essence of the cluster characteristics was allocated to each main theme and any sub-themes of significance allocated to the theme (Nigbur and Chatfield, 2025). For Anna, the process of connecting sets of clustered experiential statements and reviewing these as described above resulted in three final PETs, each with three sub-themes (Table 20).

Table 20: Anna's Personal Experiential Themes (PETs) and sub-themes

Anna	
Personal Experiential Theme 1	**The process of becoming an ACCP**
Sub-theme 1.1	Waiting for the ACCP role
Sub-theme 1.2	The learning journey - challenges and opportunities
Sub-theme 1.3	The essence of her ACCP role
Personal Experiential Theme 2	**Navigating the ACCP role**
Sub-theme 2.1	Keeping control of the role
Sub-theme 2.2	Fear and anxiety – still not fully comfortable in the ACCP role
Sub-theme 2.3	Shifting professional relationships
Personal Experiential Theme 1	**Finding a place as an ACCP**
Sub-theme 3.1	The ACCP role in bringing the team together
Sub-theme 3.2	Reflecting on team dynamics
Sub-theme 3.3	The future for the ACCP role

The final act of organisation in this stage was to record the PETs and related sub-themes in a table, along with a related experiential statement and associated transcript quote. These were checked again in context with the transcript to ensure they aligned to the representation of the participants experience, thereby providing a transparent and auditable overview of the process and interpretative decisions taken during the analysis. The table was coloured to facilitate identification later in the process (example selection provided in Appendix 8).

Step 6: Moving to the next case

Once I was satisfied that I had completed the analysis of Anna's interview, the process of steps 1-5 was repeated for each of the other participants, completing each one in its entirety before moving to the next. In accordance with IPAs idiographic approach, a core expectation of this stage is to ensure the focus remains on the next participant on their own merit (Smith et al., 2022). Careful consideration of how to recognise and mitigate any personal presuppositions or expectations ahead of the analysis is required. In particular, it was important not to seek to confirm or refute similarities with the preceding participant (Smith and Nizza, 2022). To facilitate a 'clean' perspective, I allowed myself to have a break from data analysis in between each participant.

The process of data analysis for all eight participants took approximately 10 months to complete, and having time between these allowed for my mind to be less cluttered by the previous one. Maintaining a systematic approach to each analytical step and ensuring an active reflexive attitude promoted rigour during this stage of the research, as I became increasingly confident with the method of analysis. The processes applied to each step as I moved through the cases remained constant, although some small practical changes to the formatting of the individual PET tables or organisation of the records were made

to enhance future reference to these, particularly for moving into the final step of analysis. Each participant's final table was allocated a different colour which facilitated ease in identification, particularly for later stages when cross-case analysis was undertaken. All eight PETs, along with a narrative summary, will be presented in more detail in Chapter 7.

Step 7: Develop Group Experiential Themes across the cases

The final stage of data analysis aims to highlight patterns across the individual cases which may illustrate both similarities and differences between the individuals' PETs (Smith et al., 2022). It was important to remember that the aim was not to find a definitive account or prove a theory. Instead, this part of the process sets out to highlight any shared experiences, as well as any unique or idiosyncratic findings from the individual participants (Smith and Nizza, 2022). Undertaking analysis across the cases required a similar approach to analysing the individual participants interviews, through an iterative process of moving back and forth between the parts and the whole (Eatough and Smith, 2017). This time, the participant individual experiences were the 'part', whilst the emergence of understanding how their experiences complimented or contrasted with each other formed the 'whole'. However, Smith et al. (2022) reminds the researcher that this process entails moving beyond the comparison of the PETs, and can involve moving back to look at sub-themes and experiential statements. Thus, the tenets of the whole and the parts remain central to the process of analysis, in turn evidencing a continuing engagement with the hermeneutic circle.

Practically, the first approach was to explore the individual case-level tables of PETs, to re-familiarise myself to the earlier analytical choices which formulated these. This also allowed a first impression of potential patterns across the participants' experiences. As each participant PET table was already colour coded, these were cut up, so each piece of paper represented one PET with one of its sub-themes. Similarly to the earlier analysis process, having these on a flat surface allowed a birds-eye view, providing the opportunity to rearrange these as potential connections emerged (Appendix 9). This stage generated 14 initial broad categories or emerging group themes, for example 'Planning, preparing, getting started' and 'The future'. The focus then shifted to reviewing the constituent experiential statements associated with the individual PET sub-themes. Examination of these determined that some experiential statements were either weakly supportive or unconnected to the emerging group theme, and these were then either placed in one of the other groups or put to the side to be considered again later in the process. This stage resulted in a collection of the individual experiential statements which supported the emerging group themes (Appendix 10). However, a significant challenge at this point was

in managing the volume of collective group data whilst ensuring I remained close to each individual's experience:

Excerpt from reflexive journal:

I now have fourteen broad labels – I can't call these themes yet - with a total of 361 individual experiential statements allocated to them, in a document with over fifty pages. I feel I am getting glimpses of ideas as I repeatedly re-visit these, almost like trying to see something through the mist, but I can't quite make it out. I have been getting frustrated that I am stuck with a collection of topics rather than more distinct emergent themes. I wonder if I am truly analysing the data, or am I trying to fit things into a tidy box?
Revisiting the guidance in the Smith et al. (2022) book, and my notes from Dr Elena's workshop has been really helpful. This has reminded me that I do know what to do, I just need to allow myself time (and patience) to appreciate and understand what I am finding in the data.

To manage the data, the experiential statements were distilled into shorter key words or phrases and collated into a table. Continuing to utilise the strategies applied earlier during the individual level analysis – abstraction, subsumption and polarisation – facilitated similarities, differences or other connections to become visible. Additionally, the table allowed a degree of numeration, or prevalence of my interpretation of the individual experiences. Smith et al. (2022) suggest that a Group Experiential Theme should be supported through the contribution of at least half of the participants, although they do counter that this is not a firm rule. Indeed, the significance of the 'gem', described as a noteworthy extract or illustration of an individual experience (Smith, 2011b) remains key to the interpretative process. As such, less prevalent findings were carefully considered through revisiting the pertinent experiential statements, and, if necessary, the whole transcript. This ensured a continuing engagement with the hermeneutic circle and promoted the commitment to the uniqueness of each participant's experience within the final analytical stages.

The ongoing application of the processes outlined above required the generation of a table which reflected both the prevalence of some analytical decisions, whilst allowing for any contrasting or individual findings to remain attended to (Appendix 11). Progressively, further clustering and reduction of phrases (or statements) occurred until a few core thematic clusters emerged (Appendix 12). These emerging clusters continued to be considered and refined as patterns and connections were established, until the point that I considered the creation of a final set of Group Experiential Themes (GETS) and sub-themes. To conclude this process, each GET was given a name with the aim that it would best represent the particular *experiential* finding, thus remaining true to the methodological principles of IPA (Nigbur and Chatfield, 2025). These GETs will be presented in more detail in Chapter 8.

Chapter summary

In this chapter the iterative process of data analysis has been explained in detail. Analysis has been undertaken in a way that reflects the philosophical tenets of IPA. Immersion in the individual stories gained during the interviews, and the comprehensive interpretative analysis process undertaken has led to the formulation of key findings related to the research questions. The use of an interpretative, or hermeneutic approach, as well as a clear focus on each individual is evident. The use of examples illustrates how the process evolved, aiding transparency for the analytic decisions made.

The resultant findings convey *my* analysis of the individual and collective experiences of the eight participants, and as such reflect how I have attempted to make sense of the participants experience. It is therefore inherent upon me as the researcher to effectively communicate this to others, to enable them to make sense of the findings as well. The individual participant findings (PETs) will be presented in more detail next in Chapter 7, followed by the cross-case findings (GETs) in Chapter 8.

Chapter 7 Findings – the individual participants' experiences

Introduction

This chapter will present and discuss the findings derived from the analytical interpretation of the participants lived experience, in response to the research question:

> ***What is the lived experience of critical care nurses who undertake the transition into an ACCP role?***

There is no set process for presenting the findings of an IPA analysis, although it is expected that a summary of the findings followed by an in-depth presentation and discussion of each Group Experiential Theme (GET) is provided (Smith et al., 2022; Smith and Nizza, 2022). This can be found in Chapter 8. In keeping with the idiographic essence within IPA which relies on sensitivity to context of each person's experience (Smith et al., 2022), it was crucial that the participants stories are presented individually. This empowers the reader to become familiar with the unique experience and contexts of each participant. Additionally, it allows the reader to follow, examine and evaluate my analysis and development of the participants individual themes. To achieve this, within this chapter I will introduce each participant and provide a concise narrative overview of their Personal Experiential Themes (PETs) generated from the analysis of their case, exemplifying their own experiences of transitioning into an ACCP role. Each summary is concluded with a short excerpt from my reflexive diary, which provides insights into my initial thoughts and impressions as the researcher following each interview. The findings presented in this chapter will focus purely on reporting the interpretative analysis of the participants experience without reference to the wider literature or theories relating to the wider concepts of role transition. This is to ensure prominence is given to their individual voice and experience without dilution or distraction from considering how these fit with extant literature (Smith et al., 2022).

Introduction to the participants

All the interviews were conducted between May 2022 and April 2023. The participants are all registered nurses with critical care nursing experience. Each participant will now be introduced through a short precis which aims to promote an idiographic connection to them and their story. Presentation of their Personalised Experiential Themes (PETs) will be followed by a narrative account of my interpretative analysis of the meaning of their experiences. As previously explained, to promote transparency and auditability throughout the stages of data analysis, presentation of findings, and discussion, each participant PETs table is colour coded.

The narrative account illustrates the application of the double hermeneutic, where the individual and myself as the researcher are attempting to make sense of the phenomena albeit from differing points.

The individual stories will be supported with verbatim quotations. Use of their own words ensures the participants voice remains core to the account, thereby evidencing the authenticity of the research, whilst also allowing the reader the opportunity to gauge the pertinence of the interpretation (Pietkiewicz and Smith, 2014). In many instances, several excerpts within the interview transcript epitomised the concept being discussed, however the quotations selected were deemed the most appropriate ones to reflect the core meaning of the interpretation and sense-making that I undertook for each. All participant names are pseudonyms as explained in Chapter 5. Participant quotes will be italicised, with the corresponding transcript line number given in brackets. Where necessary to maintain anonymity, minor alterations to the verbatim text have been made. For example, mention of a name or organisation will be replaced by _____ (name) or _____ (NHS Trust). Other symbols or signifiers used can be found in Table 21.

Table 21: Legend for symbols used in transcripts

Legend	Example of how it is used
"*Italics*"	When participants are repeating or expressing spoken words from other people, for example: So, she said, *"Can you assess the patient?"*
" "	When participants are repeating their own words or statements, for example: … and I said to her, "Yes of course"
Italics	When participants are stating their own thoughts, for example: I thought, *What if I get into difficulty?*
( )	Information to add to reader's understanding of how the participant expressed themselves; or emotional context; or for noting non-verbal communication, for example: (laughs out loud) (rolls eyes upwards) (covers up eyes)
……	Longer pauses or silences (up to 2-3 seconds), for example: So ……. what happened was I got the job.
Bold	Words or parts of the speech that participants emphasise, for example: And **sometimes** it is very frustrating
_____ (descriptor word)	Word has been deliberately omitted as it could identify the participant or others, for example: When I worked at _____ (NHS Trust)
[*word*]	Used to provide words or complete a word, added to the transcription by the researcher, for example: Resus[citation]
ACCP[1]	Footnote on page - to explain abbreviations or clarify meaning of specialist / niche terms, for example: [1] Advanced Critical Care Practitioner

Anna

Anna was the first participant to be interviewed. She has worked within intensive and critical care for nearly thirty years, most recently as a Band 7 senior nurse role. Anna qualified as an ACCP approximately ten months prior to the interview. Anna appeared comfortable and relaxed throughout the interview and spoke at length without any episodes of significant pauses or the need for prompts. Three PETs, each with three main sub-themes, emerged from Anna's interview (see Table 22).

Table 22: Anna's Personal Experiential Themes and sub-themes

Anna	
Personal Experiential Theme 1	**The process of becoming an ACCP**
Sub-theme 1.1	Waiting for the ACCP role
Sub-theme 1.2	The learning journey - challenges and opportunities
Sub-theme 1.3	The essence of her ACCP role
Personal Experiential Theme 2	**Navigating the ACCP role**
Sub-theme 2.1	Keeping control of the role
Sub-theme 2.2	Fear and anxiety – still not fully comfortable in the ACCP role
Sub-theme 2.3	Shifting professional relationships
Personal Experiential Theme 3	**Finding a place as an ACCP**
Sub-theme 3.1	The ACCP role in bringing the team together
Sub-theme 3.2	The future for the ACCP role
Sub-theme 3.3	Reflecting on team dynamics

PET 1: The process of becoming an ACCP

Anna shared at length the process of becoming an ACCP, a role that she had been aware of for some time but had not yet been implemented within her Trust as it had in other organisations. Anna explained her reason for choosing to wait for the role in her Trust, rather than move to another Trust to gain a trainee post, something she was aware she could have done. Anna spoke of having "*a longer journey than most in a bit of an ambulatory way (wavy movement in hands)*" (110). She explained that she chose to undertake most of the two-year ACCP post-graduate diploma in its fullest, rather than elect to gain Accreditation of Prior Learning (APL). Anna refers to feelings of envy and jealousy of the current trainees several other times during the interview (for example, lines 184-185; 502-203), particularly when accounting the infrastructure and support that the trainees have now compared to when she commenced as one of the first group of five trainee ACCPs within the critical care department.

Anna completed her course and is now established as an ACCP within the critical care team. She acknowledged that although the role is seen by some, including the clinical lead and others in the ACCP team, to be solely to fill a gap in the medical workforce. Strongly disagreeing with that view, Anna was

clear about how the role encompassed a balance between medicine and nursing, emphasising that her ACCP role was influenced by her substantial nursing knowledge and skills, explaining that:

> *…. you are drawing on those clinical skills that you have developed not just from your two-year training but previously as an ITU nurse for me* (22-23)

PET 2: Navigating the ACCP role

As Anna was one of the first ACCPs in her critical care service, navigating the ACCP role was necessary, to ensure she was able to control the pace and scope of her new advanced role. Anna spoke openly about being comfortable with seeking support or supervision from a consultant or other senior clinicians, indicating a cautious approach despite being fully qualified as an ACCP. She was mindful that "*you can run before you walk*" (67), and she recognised the need to "*play safe*" (68). This was further underpinned by an emphasis during the interview of keeping a structure in her practice to ensure that "*you're evidenced based in what you are doing, very much against guidelines"* (26-27).

Despite this, Anna described a form of reality shock, a level of anxiety experienced as she transitioned into the role. Anna appeared very aware of the potential risk to her from undertaking this advanced level role, recounting examples of times she had felt vulnerable in a situation whilst in clinical practice. However, she was confident in recognising the protection of working within her boundaries.

A significant part of the transition into Anna's new ACCP role appeared to be to find a new place in the wider critical care team. This appeared important as Anna had worked with many of her colleagues for some time in her senior nurse role, and as such she valued good relationships with many of her nurse colleagues which remained. However, Anna reported that as her role changed, some of her professional relationships shifted too. The shift in a sense of belonging also emerged from a more general change in the team culture and dynamics of working in a different way, as Anna explained. She particularly noticed this from being previously embedded in a predominantly female nursing team, whereas now she found herself in a male dominated medical team.

PET 3: Finding a place as an ACCP

Anna spoke confidently about how she was finding a place as an ACCP, in particular the ACCP role in bringing the wider team together. She discussed the importance of supporting the education and development of others in the wider multi-professional team, recognising the benefits of building trust and promoting collaborative working with others. During the interview, Anna returned several times to discuss the challenges of balancing the different expectations of her role. She described a period of her

ACCP role which had been without a clear team structure or explicit leadership. She expressed that even with a new lead in post, a compounding factor within the team was a lack of team cohesiveness and community. Anna spoke of her frustrations as she reflected on the ACCP team dynamics, and in particular her perspectives of how different team members viewed and enacted the ACCP role. At several points in the interview, she described what she viewed as the bravado of some, explaining that some colleagues valued the more emergency and advanced technical side of the role, describing this as being '*the sexy side of it*' (384) or being '*the blue light chasers'* (414). Anna felt this contrasted with what she saw as the important elements of the role.

Having been a qualified ACCP for some time now, Anna reflected on how she thought the role would continue within critical care, although she expressed some concern about the challenges for role holders in managing competing demands. As the interview concluded, Anna spoke pragmatically about the future for her role as an ACCP, recognising the changes that had occurred already and would continue to occur in the future.

Excerpt from reflexive journal:

I was quite nervous as this was my first interview. However, Anna made it quite easy for me, as she spoke confidently, at times to some length. I was struck with how relaxed and happy she appeared to be. I had jotted a few notes of key words or phrases during the interview, but I was very aware of keeping good eye contact and attentiveness during the interview. I did find myself thinking on a few occasions 'Oh, this is a really good point I can pick out'. IPA guidance says that you should "resist the urge to interpret what you are being told while the interview is still underway" (Smith et al, 2022; p.63) and so I am consciously aware of trying not doing this.
Listening back to the transcripts I noticed that my impression of her happiness stemmed from her regular use of humour during the interview, sometimes self-deprecating and sometimes with an undercurrent of seriousness, for example mentioning losing an organ when referring to an apparent unpleasant option for her career. In addition, there were over thirty episodes of her laughing at something she had said.

Alex

Alex has worked in critical care nursing roles since qualifying as a nurse just over 20 years ago, including a period working overseas. He has been a qualified ACCP for about four years at the time of the interview and has worked in two organisations as an ACCP, returning to his previous organisation after he qualified elsewhere. Alex provided a thoughtful and measured conversation. Three PETs emerged from Alex's interview (see Table 23).

Table 23: Alex's Personal Experiential Themes and sub-themes

Alex	
Personal Experiential Theme 1	**A cautious and planned decision**
Sub-theme 1.1	Wanting an advanced role
Sub-theme 1.2	A well-considered plan to get the ACCP role
Sub-theme 1.3	The challenges to get to the ACCP role
Personal Experiential Theme 2	**The meaning of nursing – now and then**
Sub-theme 2.1	Being a nurse
Sub-theme 2.2	The meaning and value of delivering critical care
Personal Experiential Theme 3	**Being an advocate as an ACCP**
Sub-theme 3.1	The need to engage others to establish the ACCP role
Sub-theme 3.2	Looking forward – promoting a better future for ACCPs

PET 1: A cautious and planned decision

Alex portrayed a sense of making a cautious and planned decision for the transition into an ACCP role. He spoke about his critical care nursing career which provided him opportunities to work in different roles, but it was following a period of working overseas and meeting professionals from other countries that he saw the potential of working in an advanced role. On his return to the UK and critical care nursing, Alex spoke of having clarity regarding what he wanted to do with his career. He was aware of the ACCP role occurring elsewhere in the country, although it was not something that was set up in his organisation at the time.

Despite identifying a distinct career goal, Alex discussed a period of serious consideration and planning before fully committing to a change in role. He initially felt some concern about making a significant change to become a trainee and describes discussing this with his family as well as within his professional circles. Alex's commitment to gaining an ACCP role became apparent as he spoke of the importance of selecting a course that met the FICM approval standards. To do this, Alex recognised the need to leave his organisation to gain a trainee role in another organisation. Despite his considered planning, Alex spoke on several occasions about sacrifices that were needed at the time. Overall, Alex reflected that "*I think I went in with my eyes open"* (420), notwithstanding some of the challenges that he encountered during the process of moving towards his ACCP role.

PET 2: The meaning of nursing – now and then

During the interview, Alex's returned on several occasions to discuss what he saw as the meaning of nursing in critical care. He spoke about the importance of having time to develop professional relationships with patients and their families. Alex described how he enjoyed the variety of patients he was able to care for in critical care, a crucial factor when he was considering his move into an advanced practice role. At several times during the interview, he referred to fulfilment as a necessity for moving into the ACCP role:

> *I saw it as what would fulfil me or continue to fulfil me in a role for many years* (153-154)

Alex spoke about being very aware of the conflicting perceptions of what a nurse does or not do as he was considering his change in role. He recalled observing other nurses moving into an advanced role, and that "*it was seen that they were almost leaving the fold and joining another group"* (298). However, he was clear about how he viewed his professional positionality, discussing how he still saw himself as a nurse. He divulged a purposeful approach to ensuring ongoing integration within the nursing team, through teaching and other activities.

PET 3: Being an advocate as an ACCP

Alex portrayed a strong impression of being an advocate as an ACCP, recognising the need to engage and be sensitive to others within the wider team. Alex recalled that as part of the first cohort of trainee ACCPs in the Trust, they had to establish the role and work to break down professional boundaries, something he feels is much less of an issue now he and others have paved the way for current and future trainees. He spoke of his approach to building better relationships with his new nursing colleagues, inferring a strategic approach with reference to having to "hit" the issue in different ways to *"try to get them onboard*" (273).

Alex appeared motivated to ensuring current and future trainees had a more informed and supportive experience and encouraged colleagues who were thinking about undertaking the role to spend time with one of the qualified ACCPs in the team. He discussed the importance of ensuring that others were shown the reality of the role:

> *So yeah, it's giving them an understanding of that as well and actually it is great when people have the awareness that it may not be the role for them* (451-453)

Alex spoke of having concerns about the impact of comments from other professionals, particularly doctors, regarding advanced practice roles which were evident on social media. Despite these concerns, as we neared the end of the interview, Alex reminded me that he had some good and positive experiences with his transition into his ACCP role overall.

Excerpt from reflexive journal:

Alex was the second participant to agree to be interviewed but timings meant he was the third interview to take place. After the relaxed first interviews, I felt nervous going into this one, perhaps as it was my first male participant, and I was unsure if the interview would be as easy flowing. Once we started however, the interview moved well through the key questions within the guide as well as some slight deviations to further explore elements as they arose. With Alex, I perceived a sense of significance about his decision-making process to go into the role. Another impression that remained with me was a clear consideration of others around him during the different stages of his ACCP training and transition. We shared an informal discussion at the end of the interview about the changing landscape of professionalism and the emergence of challenging conversations around advanced practice and other non-medical roles on Twitter, something that is of concern to both of us.

Victoria

Victoria has been a qualified ACCP for around 18 months at the time of interview. She currently works in the same organisation that she did as a critical care nurse, a role she held for approximately 8 years prior to the trainee ACCP role. Victoria appeared relaxed and in good humour during the interview. Three PETs emerged from Victoria's interview (see Table 24).

Table 24: Victoria's Personal Experiential Themes and sub-themes

Victoria	
Personal Experiential Theme 1	**An uncertain, uncomfortable but welcome opportunity**
Sub-theme 1.1	An opportunity to leave a stagnant career
Sub-theme 1.2	Unclear role expectations
Sub-theme 1.3	Expecting the worse – a lack of self-confidence
Personal Experiential Theme 2	**The shifting of her nursing practice**
Sub-theme 2.1	Changing dynamics with nursing colleagues
Sub-theme 2.2	The comfort of familiarity
Personal Experiential Theme 3	**Making sense of the ACCP role**
Sub-theme 3.1	Establishing her new ACCP role
Sub-theme 3.2	A dawning realisation of the seriousness of the role

PET 1: An uncertain, uncomfortable but welcome opportunity

Victoria's account of moving into an ACCP post appeared to be an uncertain, uncomfortable but welcome opportunity for her. She had been in her critical care nursing role for around 8 years and described that "*I'd been feeling a bit stagnant probably for a good four or five years"* (81-82). However, she recalled feeling very excited when she became aware of an upcoming trainee ACCP role being available.

Victoria commenced her trainee role just as the first two qualified ACCPs in the critical care unit were completing theirs, but she expressed that "*It's still a relatively new concept overall, particularly to the hospital I'm in"* (2-3), indicating that there were some unclear role expectations and understanding of the role. Victoria spoke of feeling lucky to have gained this role as there were other applicants from within the organisation. Despite being offered the trainee post, Victoria appeared to have expected the worse from putting herself forward for the role, stating that "*I didn't see myself as worthy* ***at all****"* (121). Once in the trainee role, Victoria explained "*I'm not going to lie, it was very overwhelming initially"* (171), and using humour to offset her sense of anxiety, she felt "*Oh I need to go back and apologise and say you'd better ask somebody else if they want the job (laughs)* (171-172).

PET 2: The shifting of her nursing practice

During the interview, Victoria discussed the shifting of her nursing practice, as she recalled some changing dynamics with her nursing colleagues, particularly when the new role was being introduced. Moving into the trainee role led to Victoria experiencing a change in where others felt she belonged:

> *I think initially the doctors were like "No, no, you are still a nurse." I think the nurses were like were "No, you've kind of gone to the medical side". Rather than a pull, like a tug of war, it was more of a push, "No you have them" (laughs)* (368-370)

Victoria recognised that her own perspective had also changed as she transitioned in her trainee role. A few times during the interview, she spoke of how she felt because of the change in her role and her professional relationships with her nursing colleagues. Despite speaking about the challenges associated with her change in role and position in the nursing team, Victoria recalled situations where she gained comfort from the familiarity of her previous role and relationships:

> *Yesterday was a nice day. There were a lot of nurses that have known me for a long time on, and I felt much more relaxed* (283-284)

Despite having doubts, she also spoke of realising that she was not completely out of her depth, "*I felt like a fish out of water until I got to the university and saw the wide array of ages, just different nations*" (158-159), and reflected on the advantages of having familiarity with the wider team during her transition.

PET 3: Making sense of the ACCP role

Victoria was able to discuss how she was now making sense of the ACCP role, and her own practice. Part of this was her realisation that of the seriousness of the role, describing this as "*a really grown-up job "* (213-214) and Victoria reflected that she had not initially fully understood the changing scope of her practice, explaining "*I didn't expect to be so independent in the role actually, to make independent decisions"* (15-16). She spoke at several times during the interview about the change in her responsibility with the new role but also explained how she has worked to improve her own confidence in her abilities, particularly by developing a systematic approach to her practice.

Victoria's transition has enabled her to establish her new ACCP role within the critical care team, and in the wider organisation. She reported that she felt *"the relationships that I've had with other staff, I would say if anything they have improved, I would say they are stronger"* (290-291). Having good relationships with her medical colleagues was viewed as important to Victoria, as she explained "*I do feel there is a change. I feel more embraced by medical, more included by them"* (275-276), and she viewed having the validation of senior doctors as a shift in culture within the workplace. She spoke of still seeing nursing care as integral to her advanced practice role. Victoria reflected during the interview about how she now saw her position with the ACCP role, stating "*I feel really privileged that I do work both sides of the fence, so to speak"* (402).

Excerpt from reflexive journal:

Victoria was my second interview conducted. My impression of Victoria was that she was a warm and humorous person. However, I perceived a strong sense of someone who at times lacked confidence or self-belief in themselves. I wonder if this is because she accidentally went into the role as the opportunity arose, and so may not have fully appreciated the expectations? At the end of the interview, after the recording had stopped, Victoria mentioned that she had found the experience cathartic and something on which she would reflect.

On reflection, I noted that I did too much talking, particularly when explaining of questions. I also noticed that I kept saying "that's interesting", something I need to be mindful of in the upcoming interviews.

Frances

Frances qualified in 2006 and has been working in critical care then. She has been a qualified ACCP for around three and a half years at the time of the interview. Frances' interview was the longest, at 1 hour and 19 minutes. Frances appeared calm and focused during the interview, and on a number of occasions appeared to take time to choose her next words during the conversation. Four PETs emerged from the analysis of Frances' interview (see Table 25).

Table 25: Frances' Personal Experiential Themes and sub-themes

Frances	
Personal Experiential Theme 1	**Developing towards being an ACCP**
Sub-theme 1.1	Preparing for the role
Sub-theme 1.2	Being in the role
Sub-theme 1.3	Being a nurse
Personal Experiential Theme 2	**Changing relationships with the changing role**
Sub-theme 2.1	Changing dynamics of nursing relationships
Sub-theme 2.2	Tension with senior nurse relationships
Sub-theme 2.3	A misunderstood role – the perception of others
Personal Experiential Theme 3	**Finding her place: an uncertain position**
Sub-theme 3.1	The challenge of keeping up skills and knowledge
Sub-theme 3.2	A change in momentum with the role
Sub-theme 3.3	Not feeling a place to belong clearly
Personal Experiential Theme 4	**An unclear future**
Sub-theme 4.1	A close or isolated ACCP team?
Sub-theme 4.2	Unclear and undefined leadership of the role
Sub-theme 4.3	A lack of role clarity and direction

PET 1: Developing towards being an ACCP

Frances spoke of developing towards being an ACCP after a developing her career within critical care nursing. She spoke of being pleasantly surprised to get offered the trainee post. However, as one of the first trainee ACCPs within the organisation, Frances was mindful that "*there was nobody who'd experienced the programme before, who was saying, you know, "Go and do a day a week here, go and do that"* (302-303), and so despite being successful in gaining her qualification, she recalls that she felt there was something lacking from her experience.

Being in the role for over 3 years, Frances described it as "*So my clinical role is quite standard as an ACCP"* (7). She did not elaborate on what a standard ACCP role meant in her context but did position the role as equivalent to junior doctors, saying they were "*doing any of the clinical roles that they do"* (11). She was mindful of the risks that could pose in terms of practicing at an advanced level but was

confident that "*as long as I work within the boundaries of my role and what I've been taught"* (445-446), this would not be a concern.

Frances was aware that as a team, the ACCPs were treated differently, potentially more favourably, than doctors on the same rota, but also appeared surprised and frustrated when encountering issues with some medical colleagues. Within her ACCP role, Frances did strongly assert her position of being a nurse within her ACCP role, confirming that:

> *I still very much feel like a nurse. If somebody calls me something, I'll always correct them and say that I'm a nurse. Erm, and I've not got massive aspirations not to be a nurse* (438-439)

PET 2: Changing relationships with the changing role

During the interview, Frances spoke about the changing of relationships as she moved into her ACCP role. Frances expressed the importance of being able to consider "*the softer side of things"* (455), which medical staff may not demonstrate. She conveyed a sense that nursing practice in her critical care unit required improving, and that she was invested in making this happen. Conversely, during the interview, Frances seemed to suggest that core nursing issues were not as important to her, at one point stating, "*You know, no interest in root cause analysis of pressure ulcers (laughs)"* (202). As her role has changed, she did portray a sense of being disconnected from the social relationships of the core nursing team.

Frances indicated that she and the ACCP team also found tensions relating to the nursing dynamics, particularly with the more senior nurse team. Initially, Frances had sought to remain included in senior meetings, but this was not successful. Frances appeared to have considered why the difficulties may have emerged, emphasising a clear difference in roles and expectations, as well as challenges during the pandemic.

On a number of occasions, Frances expressed frustration that the role was not recognised or valued as she would hope within the wider team. In particular, Frances noted that an initial commitment from the medical consultants for the role appeared to be reducing, saying that "*our consultant body, because they're all busy and we're growing team actually taking on the role of managing us is becoming quite a chunk of work"* (153-155).

PET 3: Finding her place – an uncertain position

During the interview, Frances spoke about the realities of the role as it was being enacted by her currently. She felt that learning opportunities were now reduced, reporting that "*to be honest, once*

you're qualified that tails off a little bit" (124), recognising how easily it was to lose skills and confidence in parts of the role.

Frances appeared to not want to challenge the status quo, to not want to cause any conflicts to arise, particularly when there were others vying for the experience as well. In addition, Frances spoke of evading other potential conflicts, providing an example of deliberately not using her job title in some situations. Frances did appear to recognise that she may need to be more proactive if she wanted things to change for her practice in the future.

Frances did indicate a sense of professional loneliness within her role, explaining that due to the ACCP teams' numbers and roster patterns, "*If it's really busy, you just don't have a break because there's no one else who can take over from you"* (554-555).

PET 4: An unclear future

Frances identified some concerns regarding her role, which reflected a sense of an unclear future. Being one of seven ACCPs in the critical care unit, Frances explained that "*we're quite a close team"* (170), and that all the ACCPs "*have been trained within the unit*" (93), meaning none of the current team had worked as an ACCP anywhere else. Addressing the lack of any externally experienced ACCP team members, Frances reconciled this by justifying why this may be of benefit to them, suggesting that training and employing internal staff gave the organisation a sense of control, and that taking someone from elsewhere could be a risk.

Leadership and management for the ACCP team appeared to be under some changes, and she expressed that it was unclear who was responsible for this role. Frances voiced some strong opinions as to some options for the ACCP leadership role. She viewed nursing managers as inappropriate, as "*to be perfectly honest, because they've absolutely no idea about our role"* (147-148). She also revealed that employing a lead (senior) ACCP was being considered, but again Frances felt this could lead to concerns in the team.

The lack of a clear hierarchy of leadership and management may also be contributing to the sense that the ACCP role in that organisation lacked clarity and direction. Despite having a couple of individuals in ACCP roles with several years of experience, including herself, she indicated that "*we're still just finding our feet with the role a little bit"* (9). Frances recognised that there was a need for a more fully defined role in her organisation, however, she also acknowledged that it would be difficult to define what the core skills and expectations would be for an ACCP.

Excerpt from reflexive journal:

Frances' interview went smoothly (so I thought), and I was not aware of any particularly stand-out thoughts immediately following this. During the re-listening of this a few times, I became increasingly aware that she said 'I think' or 'I don't think' around 120 times, mostly in reference to answering or discussing her experience directly. This gave me an impression of someone who appeared less confident and less certain when it came to the details of the role. The sense of a more significant change in relationships with the wider team also was prominent, and I got a sense of someone trying to assert themselves within that team. Whilst she did not talk about culture, or organisational factors as much as others, I wonder if there is a strong element of this which is causing me to think this is someone who is slightly adrift with their role.

David

David has been in the ACCP role for 11 years at the point of interview, the longest of all the participants. Prior to that he has worked in critical care nursing for most of his career and had extensive experience working in a number of different NHS Trusts around the country. David was relaxed and engaging throughout the interview. Three PETs emerged from Davids's interview (see Table 26).

Table 26: David's Personal Experiential Themes and sub-themes

David	
Personal Experiential Theme 1	**Moving towards a new role**
Sub-theme 1.1	The driving forces for his decision
Sub-theme 1.2	Beginning the transition
Personal Experiential Theme 2	**Being a pioneer – making his own way in the role**
Sub-theme 2.1	Facing the challenges
Sub-theme 2.2	Embedding the role
Sub-theme 2.3	Winning hearts and minds as an ACCP
Personal Experiential Theme 3	**The importance of future proofing the role**
Sub-theme 3.1	Protecting the quality of the ACCP role
Sub-theme 3.2	The big picture – the development of the ACCP role
Sub-theme 3.3	The future of the ACCP workforce in his organisation

PET1: Moving towards a new role

Although David has been in his ACCP role for quite 11 years, he remembered very clearly his nursing career that preceded this and spoke of it fondly. However, David appeared driven to not be "*not be tied down to that bed space again"* (182) and he conveyed a sense of having "*itchy feet"* (180) in his nursing role. Nonetheless, he was clear that he viewed all his previous nursing experience and knowledge as a very positive thing when he was looking to move to the ACCP role.

David recalls that at this time there were only a few ACCP roles in the country and there was a mixed perspective from the wider consultant team as to whether the role was necessary or required. This led to a sense of feeling quite alone and unsure as to what the new role would entail. Despite being a very experienced critical care nurse David recalls a clear shift from being confident and expert:

> *I started this role, and I felt a bit disempowered I suppose, a bit underconfident. I felt like there was a lot of things that I didn't really know and understand, although you thought you did* (201-203)

David remembered the transition taking some time, describing the need to almost deconstruct his old role to "*build it back up"* (211) as he developed into his new role.

PET 2: Being a pioneer – making his own way in the role

As the first and only trainee ACCP in his organisation, David's narrative alluded to him being a pioneer - making his own way in the role. David described having to set up and establish guidelines and protocols for his scope of practice, as these did not exist previously. He recalled facing different types of challenges, both within and external to the critical care team, citing an example that "*they hadn't got a clue. And that was hard"* (234). During the conversation David referred to 'battling' a few times and particularly as he tried to fit his role into the existing critical care professional hierarchy, which led to him experiencing a sense of feeling excluded by both nursing and medical teams at times.

David discussed the attitude of some nursing colleagues towards him in his new role, suggesting that an element of jealousy was evident: "*You almost get a sort of green-eyed monster, don't you?"* (275-276). Despite some of these recollections, David appeared to have resolved a lot of his earlier challenges and difficulties, although he acknowledged that it had "*taken years and years and years"* (236). He considered the positives of having to work hard to get his role established, expressing that "*I think that challenge sometimes makes you a better person as you work through it, and you can explain"* (282-283). During the interview, he conveyed a clear sense of change in how he and the ACCP role were viewed and appreciated within the team. He spoke of feeling valued, and gaining the trust and respect of his medical and nursing colleagues was of high importance to him. David himself was clear that he was embedding his role whilst maintaining nursing skills and values, and that he had a clear identity as a nurse.

PET 3: The importance of future proofing the role

Throughout the interview it was apparent that David placed great value on the importance of future proofing the role both on a local level within his organisation but also more widely at a national level. David spoke of the importance of ensuring standards for ACCP training and preparation were in place to promote safe practice. David strongly conveyed a sense of placing the ACCP role as a key one in the current workforce. However, he seemed concerned about a lack of clear career pathway for those in ACCP roles. Nonetheless, he conveyed a sense of optimism that thing would change for the role in due course – "*so it will happen"* (94), "*It's [pause], it's tiny steps, I think*" (80).

Drawing on his own extensive clinical nursing experience before he became an ACCP, David strongly advocated the necessity for gaining experience across a range of clinical areas before and during transitioning into an ACCP role. Focussing on his own current junior colleagues within his ACCP team, he praised their achievements but also expressed some concerns about their resilience and problem solving, as he felt that their experience had been a lot more protected than his own journey.

David appeared to want to ensure that the ACCP role was more recognised and visible in the wider organisation. This appeared to stem in part from an ongoing frustration that he conveyed during the interview, specifically that senior nurse colleagues "*…. hasn't got a clue what I do, hasn't got a clue about what any of the ACCPs do"* (292). David described several activities in which he proactively worked towards a better understanding of the role through engagement with executive level leaders.

Excerpt from reflexive journal:

David had worked in the ACCP role for the longest time in comparison to the other participants. David spoke confidently about the wider issues and the future direction for the role. I noticed that David used the term 'little' quite frequently during the interview, but sometimes in a context that appeared not to be little, for example "*a little bit of hesitation*" (193) or "*so that puts you in a little bit of a difficult……"* (258-259). This gives me the sense he is playing things down to some degree when they were more significant to him at the time.

I had worked with David for a few years until 2007, but I had no connection to him since then. During the interview, there were some occasions that had a sense of familiarity, for example when he accounted his prior experience and referenced when we first started working together "*That's when I met you guys at* _____ (Hospital)". Reflexively, I was mindful to remain close to the interview schedule to ensure the focus was on the experience he has had in his ACCP role.

Isobel

Isobel qualified as a nurse in 2005, and had around 9 years of nursing experience, much of it in critical care nursing post before she commenced her trainee ACCP post. She has been a qualified ACCP for 6 years at the time of the interview and is currently working in her second organisation in this role. Isobel was engaging to speak to, and she demonstrated a sense of good-natured, dry humour within her recollections. Four PETs emerged from Isobel's interview (See Table 27)

Table 27: Isobel's Personal Experiential Themes and sub-themes

Isobel	
Personal Experiential Theme 1	**Setting out – the start of her ACCP journey**
Sub-theme 1.1	Saw this as a clear and definite opportunity
Sub-theme 1.2	The ACCP training is hard work but rewarding
Sub-theme 1.3	Being trusted by the ITU consultant is important
Sub-theme 1.4	Feeling in-between belonging to the nursing team or not
Personal Experiential Theme 2	**Joining a new team and having to undertake transition again**
Sub-theme 2.1	Assertive approach to get the next ACCP post
Sub-theme 2.2	Having to prover herself
Sub-theme 2.3	Acceptance of her role has taken a long time
Personal Experiential Theme 3	**Positioning herself as an ACCP**
Sub-theme 3.1	Being the bridge – supporting different sides of the team
Sub-theme 3.2	Her nursing heritage is important to her
Sub-theme 3.3	Realises the early challenges were beneficial to her
Personal Experiential Theme 4	**Promoting the future of the ACCP role**
Sub-theme 4.1	Purposively distinguishing ACCP as different from an ACP
Sub-theme 4.2	The power of a team is better than being alone

PET 1: Setting out – the start of her ACCP journey

Isobel had been working in her critical care nursing role, and the unit had some ACCPs already when the team decided to expand. She saw this as a clear and definite opportunity, recalling that "*you never know when these opportunities would come around again. So, it was an opportunity to take"* (141-142). Once in her trainee role, Isobel found the reality of the role to be difficult, and she reflected on how she also worried about being able to do the training. Despite the challenges, "*It was the hardest thing I've ever done, by far the hardest thing I've ever done"* (81), Isobel recognises that it is "*also the most rewarding thing I've ever done"* (436-437).

Isobel felt supported by both other colleagues in trainee roles, as well as the existing ACCPs in her unit. This support was important, as she recalls experiencing friction and resistance to the role from junior doctors. Isobel described having a more positive relationship with senior doctors, particularly having them advocate for the role with other colleagues.

During the interview, Isobel elaborated on the feelings of not being certain about belonging to the nursing team still, something she felt originates from others not having the same opportunity. This appeared to be compounded by being familiar to the team before and after becoming an ACCP.

PET 2: Joining a new team and having to undertake a transition again

Isobel had spoken about a mostly positive experience of working as an ACCP in her first organisation. Relocating to a different region meant she need to take an assertive approach to getting another ACCP role as her new organisation did not have any ACCPs employed at that time. Isobel referred to having to prove herself again in her new organisation, despite having an ACCP qualification:

> *So I've had to work hard to prove that an ACCP can bring something to the team* (332)

She went on to describe how challenging it had been, stating that "*it's taken a lot to get them on board to be honest"* (334). Isobel feels more established in her role now, explaining "*it has taken me a long time to be ……. accepted and …… proven that I am capable of doing the role"* (38-39). She appeared satisfied that she is now accepted. However, Isobel is the only ACCP in her Trust, and the impact of this was made apparent at several points during the interview.

PET3: Positioning herself as an ACCP

Isobel described her ACCP role as important in supporting the different sides of the critical care team. She recognised the unique position her role afforded in terms of being present and accessible to others, describing herself as "*I'm a consistency, it's me that's there all the time"* (410). Isobel spoke of the importance of gaining and keeping the respect of the nursing team. She expressed empathy and understanding of the needs of the nursing team. The importance of her nursing heritage was evident during the interview. However, having joined her current team as an ACCP from another organisation, Isobel spoke of not being recognised as a nurse by other nurses:

> *I think because they have never seen me as a nurse, they just see me as (name) the practitioner, and they are like "But you can do everything" and I'm like "Yeah but I'm still a nurse"* (379-380)

Despite the difficulties that she revealed in the interview, Isobel appeared to appreciate that early challenges were beneficial to her. She recognised that at times she did not have high self-belief in what she could achieve as an ACCP, stating that "*I think it was almost reassuring that whatever you had, you are bringing something to the table. So as part of the team you can really add something"* (160-162). In particular, she reflected on her own perceived lack of experience as a critical care nurse prior to commencing her ACCP role.

PET 4: Promoting the future of the ACCP role

On a number of occasions, Isobel spoke of being a sole ACCP in her current role. The power of having a team gained particular emphasis when she discussed her future hopes for the role:

> *When you've got a team, you can do so much more than I can do on my own. ……. I've done quite a lot but likewise I can't do everything (laughs)* (463-465)

She appeared very keen to promote the ACCP role to other nurses, explaining "*So yes, it is ……. it's hard but I think it is a great career progression for ICU nurses"* (448-449). However, she also acknowledged this being a role for other allied health professionals too, recalling her first ACCP team included a physiotherapist as well.

There was a sense from Isobel that there was a need to purposively distinguish the ACCP role as being different from an ACP role within the Trust, particularly as she suggested that the Trust Advanced Practice lead "*isn't really receptive that ACCPs is a different breed altogether"* (348). Isobel also spoke at times about how she perceived a clear difference between the standards for training and education of ACPs and ACCPs.

Excerpt from reflexive journal:

I found myself liking Isobel very quickly, as she had a warm and engaging manner, with a good sense of humour. I had a sense that I knew her well although it was our first and only meeting. I considered if it were that she reminded me of someone, but I could not place it. Isobel was one of only a couple of participants who had worked in more than one organisation as an ACCP. I was struck during our discussion that her first transition into the role was probably a lot easier than her second transition, which was at odds to how I would expect a career to develop.

Matthew

Matthew qualified as a nurse in 1995 and has worked in critical care for most of this time, in a variety of roles. He completed his ACCP training in 2014, the first on his unit to do so. Matthew contacted me after I re-advertised my study on Twitter in February 2023. Matthew appeared relaxed and thoughtful during the interview. Three PETs emerged from Matthew's interview (See Table 28)

Table 28: Matthew's Personal Experiential Themes and sub-themes

Matthew	
Personal Experiential Theme 1	**Making it happen – the beginning of his ACCP role**
Sub-theme 1.1	Almost natural to move his practice forward to an advanced level
Sub-theme 1.2	Being alone as an ACCP was a challenge but minimised expectations
Sub-theme 1.3	His nursing experience is clearly a part of his ACCP role
Personal Experiential Theme 2	**Diverse expectations and understanding of the role**
Sub-theme 2.1	Frustrated to have a manager who does not understand his role
Sub-theme 2.2	The new role was clearly positioned as equivalent to a junior doctor
Sub-theme 2.3	He was seen as a bridge between nursing and medicine
Personal Experiential Theme 3	**The need for change for the future**
Sub-theme 3.1	A role which is unclear to the organisation
Sub-theme 3.2	Realises the importance of role development
Sub-theme 3.3	A personal change – deciding to leave the role

PET 1: Marking it happen – the beginning of his ACCP role

Matthew spoke warmly about his career in critical care nursing before he became an ACCP. As a senior nurse, increasingly taking an active role in initiating patient interventions, he considered the move toward advanced practice as "*it was a natural progression"* (137-138). After returning from a secondment to another area as a practitioner, he explained that he got an insight into working at an advanced level.

Matthew was involved with early discussions and the planning within the organisation to develop the role and along with a colleague from another ITU in the organisation, "*we were the first two in [region] doing this role"* (19-20). Despite having another colleague on the course, Matthew found it challenging to being the sole ACCP trainee on his ITU. Matthew recalled this time as being under scrutiny and he particularly remembered more overt resistance to the new role from doctors. Despite the substantive time in planning for the role, Matthew explains that he felt that "*There was very little support"* (84) during the training and transitional period.

Despite the wider issues, Matthew spoke positively about how his nursing colleagues accepted his change in role. Matthew was also able to discuss how his nursing experience is part of his ACCP role. During the interview, he sought to align his new role to nursing, explaining "*…. in my nursing role, if you call it that, you know I am still a nurse, but just as a way to make it different (pause)"* (175-176).

PET 2: Diverse expectations and understanding of the role

Matthew spoke of the varying reactions and expectations of others regarding his new ACCP role. One of the challenges and frustrations he discussed was the management and oversight of the role. In particular, he mentioned a change in his manager from an earlier one who supported the new role:

> *then getting managed by different people over time who perhaps don't get ACCPs, it's quite hard* (214-215)

During the interview, Matthew spoke about the scope of the role, initially explaining that "w*e very much did a junior doctor's role"* (66), with an expectation that "*we'll cover gaps elsewhere and just move around as needed"* (123). Matthew appeared mindful of the potential impact his change of role would have on nursing colleagues. Considering this, Matthew found that "*the nurses kept on saying I was now their bridge to the doctors"* (188-189).

PET 3: The need for change for the future

Matthew spoke on several occasions about the wider organisational experiences he has encountered whilst in his ACCP role, and to some extent continue to be present in current times. Matthew spoke of his frustration that the organisation issues he experienced are still evident now. He suggested a reason for this could be because the role "*doesn't fall in a neat nursing role or medicine role, they often don't really get it"* (232-233).

As a very experienced ACCP, Matthew was mindful of how future ACCPs prepared for and developed in their role. He spoke of the importance of coming to the role with a range of skills and experience. Matthew also discussed the importance of role and career development, recognising "*that a lot of my younger colleagues could be doing this for another 30 years"* (276-277). As the interview concluded, Matthew described how he had made the decision to leave the role, stating that "*It has just been really difficult"* (306).

Excerpt from reflexive journal:

I enjoyed talking to Matthew and found his story one of ups and downs as he moved into his role. Matthew had declared he was leaving the ACCP role but had not said why prior to the interview. I wondered if he would use this as an opportunity to air any issues he had, but that was not the case. However, he referred several times to other who did 'not get it' and I got a sense of someone who is no longer satisfied to work in a role with ongoing constraints.

Emily

Emily qualified as an ACCP in 2017 and has undertaken the role since then (6 years). She has worked in two organisations as an ACCP. Prior to this she had extensive critical care experience, as well as undertaking an advanced practice role in another speciality. Emily's interview was the shortest at 51 minutes, however she spoke confidently with little hesitation or pauses. Three PETs emerged from Emily's interview (See Table 29).

Table 29: Emily's Personal Experiential Themes and sub-themes

Emily	
Personal Experiential Theme 1	**The reality of becoming an ACCP**
Sub-theme 1.1	Finding her way to the ACCP role
Sub-theme 1.2	Managing the transition
Personal Experiential Theme 2	**The meaning of advanced practice to her**
Sub-theme 2.1	Finding a place as an ACCP
Sub-theme 2.2	Situating the ACCP role as a medical one
Personal Experiential Theme 3	**Leading the ACCP team**
Sub-theme 3.1	Working hard to get the new role and team set up
Sub-theme 3.2	Important to her to ensure the new ACCP team has clear governance
Sub-theme 3.3	Forming professional alliances

PET 1: The reality of becoming an ACCP

Emily appeared happy to discuss the reality of becoming an ACCP. She had a lot of critical care experience before taking an opportunity to be seconded to a Matron role, but it transpired that "*I realised actually the matron route wasn't what I wanted to do"* (7). However, during her time in the organisation, she had positive encounters with advanced nurse practitioners which made her want to explore this option for her career. To enable this, she took action to make it a possibility, explaining:

> *So I went off and did my health assessment masters module and non-medical prescribing [NMP] myself* (12-13)

Recognising she still had limited support to move into an advanced level role in critical care, she took an advanced practice role in another speciality. However, she chose to return to critical care after seeing an advertisement for a trainee ACCP role in another Trust. When asked about the role, Emily recalled that "*I didn't really know anything about it to be honest"* (161) but spoke confidently about wanting the role and knowing at that stage it was what she wanted for her career. Despite this, Emily particularly recalled the experience of a shift in her confidence during the early stages.

Having trained and transitioned into the ACCP role in one Trust, then moved again into a new team in a different Trust, she recalls quite different experiences with the critical care nursing teams. She explained

that she had a positive experience of being accepted in the first team, however, there were more challenges in the second Trust, as she was the first ACCP in the team.

PET 2: The meaning of advanced practice to her

Emily appeared to hold strong, and sometimes contradictory views, about the meaning of advanced practice, and where advanced practice and the ACCP role was situated. When she recalled her first advanced practice role, before training as an ACCP, she referred to it as a medical role. In addition, she confirmed that the ACCP role was aligned to medicine, stating "*You are completely 100% part of the medical workforce"* (238).

However, during the interview, Emily resisted the notion that the ACCP role was simply a replacement role for doctors. She went on to explain how traditional training rotas and expectations were not easily applied to ACCPs. Emily also made it clear she was able to assert her view about the ACCP role and responsibilities, stating. In another part of the interview, Emily distinguished her role as being outside of the nursing team. However, Emily did make it clear that she very much valued her nursing qualification, confirming "*I truly believe I am a nurse. I am quite happy to stay under the NMC"* (331).

PET 3: Leading the ACCP team

A significant focus within the interview was around Emily's current role as a lead for an ACCP team in the second Trust. She spoke of having to work to get the new role and team set up in the organisation. Emily clearly placed a lot of value on how she had experienced the ACCP role in her first Trust and spoke of wanting to role-model that in her current role. One element of her role that she emphasized as being important was the support and supervision of her trainee ACCPs. This extended to ensuring consultants were actively supporting the trainees too. She explained "*I make my guys have their supervisor meetings"* (223), elaborating that "*if their consultants, it's their ITU week, my guys will work the entire week, so they are having 1 on 1's"* (224).

From an early point in her post, even before starting, Emily appears to be confident to take control and involvement around the planning and construction of the ACCP team. One specific concern she had was to ensure that her new team had clear governance in place for the ACCP role, particularly:

> *because I've come from a Trust that has that governance and standardisation, I came into this Trust thinking (pulls a face), hmm, you can't do that (laughs). Hence why I re-wrote everything* (321-322)

As well as a clear focus on leading and developing her ACCP team, during the interview Emily spoke about the importance of developing and maintaining relationships with different members of the wider healthcare team. She expressed a strong relationship with her critical care medical colleagues but also remembered some earlier challenges with doctors. Reflecting on her experiences discussed during the interview, it seemed important to Emily that future nursing colleagues who were considering an ACCP role understood the role and the commitment needed.

Excerpt from reflexive journal:

I recall feeling very lucky to have accidentally found Emily, as she was the only lead ACCP in my participant group. I wondered whether her experience would have any significant differences from the others. But then I remembered – of course all my participants' experiences are significantly different due to the uniqueness of them as individuals. So when I interviewed Emily I ensured I wasn't distracted with seeking some kind of 'gem' (Smith, 2011b) but that I remained attentive to the interview in that moment. Whilst Emily answered the questions, she did not dwell on her earlier experience or her training in much detail but instead provided a strong insight into her beliefs and values of the ACCP role.

Chapter summary

The findings presented are a shortened synopsis of my interpretation of the individual participants description of their experiences relating to the transition into an ACCP role. It represents their perspectives and experiences, with underpinning examples from the interviews. The use of the raw data was important to allow the reader to appreciate the analytical process and emergence of the PETs, contributing to the trustworthiness of the findings. It is recognised that the use of only selected parts of the interview may appear to show a fragmented account of their story. However, pragmatically it was determined that more depth would be given to presenting the cross-case analysis findings, which follows in the next chapter.

Chapter 8 Findings – cross-case experiences

Introduction

This chapter will explore and present the findings from the cross-case analysis of the eight individual participants, following the process outlined in Step 7 as detailed in Chapter 6. Three GETs and nine sub-themes derived from the data analysis process will structure the presentation of this section, and are surmised in Table 30:

Table 30: GETs and sub-themes

Group Experiential Theme	Sub-theme
GET 1: "An explosion of a role" - navigating the transition	The move to a new role
	Power and control
	Changing nursing dynamics
GET 2: "There to care" – negotiating their identity and place	The psychological and emotional impact
	Praxis – being a nurse
	Establishing a sense of belonging
GET 3: "I think it will get better, won't it?" – vulnerability, concern and hope	An uncertain future
	The need for role governance and leadership
	Reflections of the COVID-19 pandemic

Each GET represents the most significant level of shared experiences, with sub-themes representing a greater level of detail into the experiences which converge towards the GET. In addition, key concepts within each sub-theme further illustrate how the different individual experiences reflect or contrast into a shared phenomenon. Whilst considering any similarities (convergence) or differences (divergence) across the accounts, I remained cognisant that any interpretative choices remained embedded in and from the participants' narratives. Therefore, the GETs, sub-themes and the related concepts have emerged as a result of my interpretation of the experiences of the ACCPs, in other words, how I have made sense of their own sense making through the application of the double hermeneutic (Smith et al., 2022). It is important to note that whilst these have been organised and presented in a tabulated format, the nature of the experiences is much more dynamic. Consequently, there will be some overlap or merging of concepts within and across the different GETS and sub-themes. Synthesis of themes and concepts will be necessary during the Discussion in Chapter 9.

Each GET will be presented, drawing on illustrative quotes from the participants to underpin that the interpretations are grounded in the data. Where necessary, if there are similar quotes or topics, the most prominent one will be selected to make the point. It is the deliberate intention to do so without any reference, consideration or distraction from wider literature or theoretical frameworks. As outlined earlier (see Table 21), the use of symbols or signifiers may be used to aid the presentation of the exemplar. A more detailed outline of the GETs and sub-themes showing the prevalences of the analytical clusters can be found in Appendix 13.

GET 1: "An explosion of a role" – navigating the transition

*"Because it is like an **explosion** of a role [hand gesture to show explosion]"* (Anna; 69)

The first theme is concerned with how the participants' experienced beginning their transition into the ACCP role. Across the narratives, there was variance around the drivers for making this career move, and in the pre-understandings of what the role may entail or how it may impact on their professional practice. All participants recalled challenges as they transitioned into their trainee role, depicting episodes of control, conflict and marginalisation. Common across the experiences was a significant form of 'reality shock' which threatened their ability to understand their identity and position within the critical care team.

GET 1 consists of three sub-themes – *The move to a new role; Power and control; Changing nursing dynamics*.

Sub-theme 1: The move to a new role

This sub-theme represents the starting point of the participant's journey into their new ACCP role. It encapsulates the considerations and perspectives which influenced their individual decision-making to undergo a change in role. The participants all had significant amounts of experience within critical care nursing when they began their ACCP career move (as shown in Chapter 5: Table 12).

Across the accounts, participants referred to the desire to remain in critical care. For example, David spoke fondly about his extensive critical care nursing career which commenced with a placement when he was a student nurse, explaining that "*I've never really left intensive care since then*" (132-133). Matthew and Alex recalled similar feelings, with Alex clearly articulating his commitment to remain in the speciality:

I really wanted to focus on my critical care skills and found that's something I wanted to go in to. And that is one of the big focuses of the ACCP role (70-71)

It was apparent that without the opportunity for the ACCP role, participants viewed their career options in a limited and non-positive way. For example, Victoria described herself as "*been feeling a bit stagnant"* (p. 81-82) in her ITU nursing role. Similarly, David described a time in his career where he felt "*constrained again"* (p. 169-173), alluding to having a sense of restriction in his nursing role. He went on to describe how he felt: "*I was getting a bit itchy feet really, you know, from being able to open my wings"* (180-181).

With one of the longest nursing careers, Anna recognised that "*you know in nursing you can decide to go down the management route, and I didn't want to go down the management route* (146-148). Having had experience working in different senior nursing roles, both David and Emily found this served to reinforce what they did not want for their careers:

I always thought I was going to follow the route of a matron in ITU but when I went to [NHS Trust] and had the opportunity to do it as a secondment from work I realised actually the matron route wasn't what I wanted to do (Emily; 5-7)

[Sighs] I didn't really like that as much because I went from working as a charge nurse in cardiac ITU, with balloon pumps, and pacing and opening people's chest and things, to a 2-bedded hospital up in ____ (location 2) (David; 145-147)

Underlining this point of view, Anna and Isobel explicitly positioned the ACCP role as one which affords another career opportunity for senior ITU nurses. Participants highlighted that the ACCP role stood out as allowing the nurse to remain 'hands on' delivering direct clinical care. This suggested that undertaking other senior nurse roles in critical care – such as Outreach, a senior sister / charge nurse role, or the Matron role – did not afford this, which participants were keen to highlight:

I've always wanted to be clinical rather than sit in an office type role (David; 5)

as soon as you were Band 7, you're in the office, which I had absolutely no interest in doing (Frances; 201-202)

I didn't want management. I didn't want that at all. I'm very much patient orientated (Isobel; 140-141)

These comments demonstrate a degree of polarisation between how the ACCP role and other senior nurse roles in critical care were viewed by the participants.

Across the participants, there appeared to be a tension between the motivation and drivers for deciding to go into an ACCP role, along with associated emotions, worries and considerations. For Anna, Alex, David, Matthew, and Emily, the ACCP role had been a clear career goal for which they had been active to secure a position. Matthew viewed the role as "*a natural progression"* (138) to what he was doing in his senior nurse role. To support this, he explained how he would be co-ordinating care and providing instructions for doctors for interventions that he knew were needed but was not able to provide within the scope of his role. Anna's motivation was also underlined with a similar example of leading on the management of a critically ill patient, and recognising that "*I want more of this, I can do this"* (142). Alex also spoke of feeling "*there was a bit more I needed to do"* (80) with his own nursing practice. These views are indicative that the participants felt constrained by their role boundaries, particularly that they understood what a patient required but could not fully enact it.

For Anna in particular, it was a longstanding goal to become an ACCP:

> *it was always something I wanted to do for years and years before. I always wanted that role. It was something muted around for like, three decades* (150-152).

She reflected on why she had not moved to another organisation sooner to gain a trainee role, describing that "*some of it is laziness, some of its, it's comfortable staying where you are"* (157-158). She appeared to want to justify her choices, speaking of the importance of feeling comfortable and having the support of a team that knew her. Anna's comments revealed a level of carefulness about moving into the role despite having a clear drive for the role. A sense of caution and hesitancy was also apparent in Alex's experience. He talked about seeking advice from a colleague who was doing the role elsewhere, explaining "*so I really drilled him down on what his training was like"* (159-160). Alex had undertaken careful planning for the role transition which included a move to another organisation for the training and consolidation period. Considering the financial and geographical challenges he faced, Alex accepted that "*I was going to put some sacrifices in the way for a couple of years of, you know, of hard work to get to that end point"* (137-138).

Alex referred to the 'sacrifice' he made a couple of times, reflecting a willingness to accept the impact to reach his goal of becoming an ACCP. Emily wanted to gain an advanced practice role in critical care

for some time, but with no opportunities in her organisation, she worked in an advanced nursing role in another speciality for a while. She recalled being motivated when she saw an advert for the ACCP role, explaining "*I was like, 'Oh wow'"* (166), and confidently thinking that "*I knew it was for me. It had my name on it"* (193). This allowed Emily to return to critical care specifically to start a trainee role.

Anna, Alex, David, Matthew, and Emily had all had all been aware of the role and had been active in wanting to attain it. In contrast, Victoria, Frances, and Isobel shared a more 'accidental' move into the ACCP role. Although it seems like the ACCP role was not an established career goal, Victoria appreciated it was a timely opportunity, recalling:

> *when the ACCP role came about, it's the only time that my eyes lit up and I felt butterflies in my tummy* (tone picks up, smiling a lot*) for my career again actually* (p.80-81).

Similarly, Isobel recognised that "*you never know when these opportunities would come around again. So it was an opportunity to take"* (141-142). However, more pragmatically she recalled thinking "*Do I, or don't I? I've got nothing to lose"* (109) when she made the decision to apply. Isobel had been happy in her nurse role, and these comments suggest a sense that she would not have been disappointed if she had not gained the role. Other participants also spoke about having a back-up plan in case the ACCP role was not successful. Alex was reassured to know *"if it didn't work out there was always a job for me"* (176), whilst Victoria acknowledged *"Oh yes, so it did cross my mind would I go back to nursing?"* (395).

Despite the preparation and consideration of the decision to apply, there appeared to be significant challenges during the trainee period, particularly when a lack of structure to the training occurred. Some of the participants had previously undertaken elements of advanced practice education including non-medical prescribing prior to formally getting their ACCP post. This meant, for some, revisiting or retaking prior learning, as "*I didn't feel credible'* (Anna, 117-119) or for Emily *"…if you were on your own you need to be competent*" (188).

All the participants spoke of understanding the commitment required for both the academic and the work-based learning, although for some this was a challenge. Frances recalled that "*there was nobody who'd experienced the programme before, who was saying, you know, "Go and do a day a week here, go and do that"."* (302-303). Similarly, Isobel and Anna recognised the need to take the lead in arranging their own learning opportunities to get the optimum experience to support their role transition. Each participant spoke of their individual commitment to ensuring they would be successful with their

training requirements for the role, and there was a clear sense that the participants viewed the training requirements as both a challenge and an opportunity for their progression.

Sub-theme 2: Power and control

All participants referred to challenges they faced as they transitioned into their new roles. Participants experienced an uncertain period, typified by examples of role ambiguity, power and conflict concerning their ACCP scope of practice and how their role was to be enacted.

Views and opinions held by medical staff about the ACCP role contributed to the impact of the transition. Matthew experienced very explicit resistance to his new role, recalling: "*we did have some quite negative comments from consultant colleagues who just didn't want us doing it. They said we were doing a doctor's role without being doctors (pause)…."* (153-154). David and Isobel spoke of mixed acceptance for their roles from consultants. Isobel's transition had "*been a challenge (smiles)"* (329), a phrase that belied a significant sense of frustration. She explained that "*some of the consultants were dead set against it from the off. Didn't want ACCPs. Don't need ACCPs"* (329-331), which she accounted to "*a culture that's been like that for years"* (427-428). David also experienced "*a few barriers and obstacles put up by some of the consultants. Some wanted it, some were very keen. But there was quite a few who didn't really want it, didn't really understand it"* (12-13).

Emily was very clear that moving into an ACCP role meant she was seen as "*completely 100% part of the medical workforce"* (238). Her use of the word 'completely' implied a level of confidence that she had about her position in the wider team. Similarly, Alex, Frances and Matthew all considered their role to be equivalent to that of a doctor (junior doctors for Frances and Matthew, and a registrar for Alex). They all stated that they were in effect 'doing the role' as the doctor would be, but it is important to note that there is a significant difference in what a junior doctor and registrar does within critical care. Victoria provided a contradictory perspective on her role. Early in her interview, she stated "w*e don't blend in with the medical team as such"* (34-35). Later, she recalled an encounter with her lead Consultant which appeared to reiterate a lack of understanding of where the ACCP role was positioned:

> "*I remember walking in one morning and going "Hi boss", and she looked behind her and said, "I'm not your boss", and I went "Yes you are" (laughs)"* (371-374).

In contrast, although Anna acknowledged that her role in part was "*filling a medical gap"* (54), she countered this view, stating:

> "*We are very much heavily told you are medics so think medics. I am not a medic (shaking her head). There is nothing in FICM, nothing in the ACCP world that says that I have to say that"* (406-408).

She was keen to highlight a clear difference expressed by some of her ACCP colleagues: "*I notice some of my other ACCP colleagues have said they don't feel like nurses anymore, they are absolutely medicine"* (333-335).

Despite the differences expressed, becoming an ACCP required integration into the critical care medical workforce, a process organised around staffing rotas. Rotas were typically described as being a registrar /Tier 1 (or airway) rota, a second tier (non-airway) rota, or a distinct ACCP rota. Isobel explained that she was not permitted to be on the registrar / airway rota as the sole responsible clinician, describing this as "*still a little bit of a bone of contention"* (37-38). This appeared to reflect a long-standing issue regarding not having her ACCP role and experience accepted, something that she spoke of on several occasions. On the other hand, Anna was reluctant to be viewed as equivalent to a registrar:

> *We fill the gap in the registrar rota if there is shortfall in staffing. That doesn't sit well for me because I'm not a cheap registrar and I shouldn't be (laughs) seen as that* (96-97).

These excerpts show a level of control over the positioning of the participants' role which was unwelcomed. However, Emily and Frances spoke of how control was exerted over their rotas which favoured the ACCPs more explicitly. Despite her previous statement about the position of ACCPs in the medical workforce, Emily strongly resisted that ACCPs would be replacements for junior doctors in the workforce rotas, recognising the differences in their role and career trajectory. Similarly, Frances explained:

> *the consultant who writes the rota is very appreciative that this is our sort of lifelong job and our rotas reflect that. You know, we don't do as many nights and weekends as the other trainees do, because you know, the other the trainees know that, you know, it's a bit rubbish for a few years, but then essentially, they'll become consultants and not work as many* (56-59)

The variance in the recognition of the ACCP role contributed to a lack of role clarity, exacerbating the degree of control over the ACCPs scope of practice. This was exemplified within Matthew's role which appeared to fluctuate at times, depending on "*on the workload and the consultant"* (68-69). Frances also conveyed a sense of uncertainty about the scope of her role, describing herself as: "*just finding our feet with the role a little bit"* (9). Victoria recalled being informed by one Consultant that:

> *"I treat you like you are one of my trainees", "I treat you exactly the same", she went, "I don't see any difference in you apart you can't intubate yet"* (236-238).

This statement, whilst slightly contradictory, illustrates a perception that ACCPs should not, or could not, undertake advanced clinical skills and procedures which were expected for doctors. Anna and Emily were keen to highlight a degree of caution in relation to the acquisition of such skills. Both chose to undertake significant training and supervised practice to establish a level of confidence and competence in advanced airway management. However, Frances raised expressed concerns about what skills an ACCP should or should not have: "*I think it's very challenging to market it by specific skills because, you know, certainly airway skills aren't something that everybody wants to have"* (78-79).

Keeping control of the role and maintaining safe practice as an ACCP was clearly important across the participant accounts. Anna was very vocal throughout the interview about managing risk within her role, recognising that she could be in a vulnerable position "*if I mess up"* (517). She explained with emphasis that she was "*very **clear** on what I can do clinically and I'm also very clear where my gaps are"* (138-139). Participants exercised a level of caution with their new role, typified through seeking support or supervision from senior colleagues. Adherence to evidence-based guidelines and protocols formed an important mechanism for practicing within safe boundaries. For David and Emily, this meant actively establishing new guidance to ensure role governance and safety:

> "*because I've come from a Trust that has that governance and standardisation, I came into this Trust thinking (pulls a face), hmm, you can't do that (laughs). Hence why I re-wrote everything"* (Emily; 321-322).

Being confident to express concerns or refuse to undertake practice outside their scope was also a strategy employed to keep control. Anna captured the potential implications, adding "*I'm not ready to lose my PIN number quickly (laughs)"* (78).

This sub-theme shows a difference in how the ACCP role was perceived by the ACCP and the medical staff. Interpersonal challenges with other colleagues, particularly other nurses, was not an uncommon finding and will be explored in more detail in GET 2.

Sub-theme 3: Changing nursing dynamics

During their transition, the participants experienced significant changes to relationships with other nurses in their critical care team. A lack of understanding and insight into the ACCP role appeared to

contribute to difficulties for the participants to fully enact it. This manifested through a range of difficult or challenging behaviours by nurses towards the ACCP.

Marginalisation from nursing team activities, such as being left out from senior nurse meetings was experienced by several participants. Frances viewed this as a deliberate decision taken by her colleagues, as she recalled being told "*I don't know why you're here sort of, you know this doesn't include you"* (345-346). It was evident that this was an impactful experience, as she described: "*I can't think of another word to use, some* ***intimidation*** *with the role"* (339-340). For Isobel, being excluded from nursing matters was contradicted by expectations that she knew about certain issues:

> *I don't get included in anything senior nursing, but then they'll say "Oh, have you not heard about that" and I'm like "No, should I have?" (shrugs shoulders)"* (284-285).

David had similar frustrations. He explained: "*you are cut out of the email trails and information form the nursing side because you are not a nurse* [does "quotation marks " with hands when saying 'not a nurse']*"* (292-294). Anna also spoke of being excluded. She recalled a recent situation where she felt let down by her senior nurse colleagues following a complaint made by a patient's relative. Explaining that the medical team were quick to assure her of their support, this was different to the response from the senior nurses: "*So yeah, it felt a little bit like being shut out in the cold, Oh I'm not a part of you anymore"* (332-333).

It was apparent that being excluded led to an uncomfortable realisation of feeling unsure where they fitted in within the team. Victoria described a clear sense of uncertainty about her new ACCP role, reflected through both the nursing and medical teams not understanding where the role fitted in:

> *I think initially the doctors were like "No, no, you are still a nurse". I think the nurses were like were "No, you've kind of gone to the medical side". Rather than a pull, like a tug of war, it was more of a push, "No you have them" (laughs)* (368-370).

Whilst Victoria appeared bemused when recounting this, she had evidently experienced a time when her professional relationships and sense of belonging were unclear. In a similar way, Frances described being "*a bit out on a limb sometimes"* (347) as she reflected on her own situation.

As well as a degree of exclusion exhibited primarily by senior nurses, some participants experienced overt resistance to their ACCP role by other nursing colleagues. Examples of not being listened to implied a deliberate dismissal of their role. Isobel shared a situation she encountered:

if you go in to do your daily review and they'll say, "Oh well, blah blah blah and such and such, but when the doctor comes in, I'll speak to them about that". And there's always the frustration of, "Well, I'm not a doctor, but that's my role and you know, please tell me these things" (353-355).

Similarly, David remembered having:

Lots of challenging behaviours, erm, especially when I was more qualified and wanting to implement treatment plans and change prescriptions and things, and it was 'Are you sure you can do that' or, you know ' I don't agree with that' and things (14-16).

Both of these extracts highlight how nurses undermined the new authority the participants were trying to establish in their ACCP role, something that was not necessarily expected. Alex recalled being surprised when experiencing resistance from nurses in his ITU:

But I hadn't actually appreciated how much resistance there was at _____ (NHS Trust 2) from the nursing fraternity rather than, you know, I though the resistance would be from the medical team (320-322).

He added that his medical colleagues were quite bemused by the conduct of the nurses:

they all admitted that they hadn't had any awareness that the nursing profession would eat their own colleagues as much as they were trying to do (laughs) (287-289).

Alex's use of the term 'eat their own' reflects an idiom, which implies a social situation where members of a group turn on or attack another member of that group, typically seniors impacting on juniors. Victoria appeared to have this in mind when she described herself as a 'cannibal' following a situation with nursing colleagues:

Yeah, funnily enough I called myself a cannibal last night (laughs). I was feeling a bit frustrated at one or two of the nursing team yesterday (247-248).

Although there was no explicit mention of any physical harm or threat, there is a sense that the negative behaviours displayed towards the new ACCPs was not expected or welcomed. For example, David spoke of having to "*battle a lot"* (229) to gain inclusion and acceptance. In a similar manner, Isobel described her experience as a form of power struggle with senior nurses, explaining:

they will try and ……. almost pull one up on you, get one up on you, if you see what I mean, just to prove that they still know something more than you do. And so in some ways that's the bits that absolutely drive you mad (277-279).

Reflecting Davids words, she recognised that the current ACCPs "*still have a bit of that battle now, even still"* (273).

Across the interviews, there was consideration for why the nursing team may have manifested what was viewed as negative behaviours in the manner described above. Alex offered a sympathetic view towards nurse colleagues:

I think they hadn't invested or informed any of the nursing team. So I don't think there had been as much investment in them to explain what they wanted to achieve or what was going to be achieved at all (282-284).

Victoria held a similar view, explaining that "e*ven from upper levels actually, the senior charge nurses, I think they didn't entirely understand the role"* (265-266). Emily was bemused to find nurses were unsure of her role/ capacity:

the*y just didn't know to start with. "Oh, can you prescribe?", "Yeah, I can prescribe". "Could you do a cannula?" Yeah, I'll put a central line in if you want" (laughs)* (309-310).

Other participants appeared more frustrated that other nurses, particularly the senior nurses, did not understand the ACCP role. Putting it directly, Anna was keen to highlight a lack of active interest from her colleagues, stating:" Honestly*, they [nurse manager/ leaders] don't interact with us. They don't interact with us, they have nothing to do with us"* (311). David also spoke bluntly, conveying irritation that his nurse leads "*…hasn't got a clue what I do, hasn't got a clue about what any of the ACCPs do"* (292). Substantiating this comment, he spoke about the lack of recognition and appreciation that ACCPs were an asset to the nursing team:

I've said to them, out of all your nurses in your division your ACPs especially in surgery and ITU ACCPs are your most senior nurses. They've got the most experience, they've been here the longest, they're the most qualified but you don't include them. And it's like, "Oh" (303-306).

The lack of knowledge and understanding about the role by nurse colleagues was a strong recurring pattern across the interviews, but other factors were also considered by some participants.

Anna, David, Victoria, and Isobel all suggested that a degree of professional jealousy may be at the core root of things, illustrated by Victoria who suggested that "*sometimes it feels like resentment"* (270-271) towards the role. David's perception of why he experienced negative nursing attitudes was similar:

> *I think some of it was maybe a bit of jealousy as well, you know looking at this is a new role, it looks interesting. You almost get a sort of green-eyed monster, don't you?* (274-276).

A unique view for Isobel was that nurse colleagues' jealousy was centred around the positioning of them as 'older', for example:

> *I think some of that is a jealousy thing and if they were younger they probably would have done it themselves or wish they could have done it themselves* (215-216).

She differentiated between herself as 'younger' and others as 'older' and 'bitter' a few times during her interview. This appears to suggest that she saw a comparison between nurses who are motivated to take the opportunity such as the ACCP role, and others who may be more fixed in their mindset and role.

GET 2: "There to care" – negotiating their identity and place

> *"we are ultimately there to care for the patient"* (Alex; 385)

The second theme details a move away from a period of surviving the initial transition period as a trainee ACCP, to one of thriving in the role. Participants experienced a range of emotional and psychological tensions and challenges, utilising both internal and external factors to help them to establish and understand their new role. Despite the conflicting positioning of the ACCP role by others in the team, participants adapted to becoming an ACCP, locating their nursing professional identity and heritage within their new role.

Three sub-themes – *The psychological and emotional impact; Praxis – being a nurse; Establishing a sense of belonging* - were brought together to create this overarching GET.

Sub-theme 1: The psychological and emotional impact

Participants reflected on the internal and external factors which affected their transition. The impact on emotional and interpersonal experiences was apparent as the participants spoke of how they navigated through to a position of feeling more settled in their new role.

Anna, Victoria, and Isobel spoke positively about the impact of having strong support from their consultant colleagues during their training. Isobel recognised that her transition was helped as "*the consultants had done a lot of the groundwork before we were even in post"* (319-320), suggesting high level patronage for the role. Anna felt confident that her consultants understood her limitations, explaining:

> "*my consultant is not going to turn around to me and ask me for a weird and wonderful test or investigation for a certain thing, because they know that's not where my knowledge lies (laughs)"* (265-266).

Similarly, Victoria explained that:

> "*They know you, they know you quite well, you know "I know _____ (name), she just needs a little bit more of …. come on you can do it""* (194-195).

For these participants, having a degree of familiarity helped with their transition, providing a sense of safety and security.

However, familiarity within the ITU team was not viewed as an advantage for all participants. Alex found it beneficial to be a trainee in a new team: "

> *actually for me going to another hospital was completely the right thing to do to train because nobody was going to ask me about the rota at _____ (NHS Trust 2), and if they could swap their shifts"* (314-316).

Whilst Alex's reasoning appeared to stem from a need to distinguish himself as being in a new role, for Emily it was more of an emotive consideration:

> *No-one knew me. They didn't know my skill set. I could have been absolutely rubbish for all they were concerned. And so I actually could be rubbish and say, "I'm rubbish" and start afresh* (202-204).

Emily's comment conveyed a sense of fear or anxiety about the transition, which was echoed within other participants experiences. At different points in her interview, Victoria discussed aspects of feeling fear and anxiety in her trainee role, explaining "*I'm not going to lie, it was very overwhelming initially"* (171). Attempting to explain this, she stated: "*I think initially the fear of, well I felt like a meercat especially in the first year, "Oh my god, if something goes wrong, I need to be able to fix that, do*

something about that" (moves head side to side – like panicking)" (285-287). Isobel and Anna also spoke of significant episodes of stress and fear. Anna described how she felt even now she is qualified: "*There are still shifts I go to work, and I feel physically sick thinking, err, actually will I be good enough today"* (168-169). Anna described this as "*the four o'clock in the morning"* (88), explaining how she would wake up and be analysing what she did or did not do on her clinical shift. Isobel also reported similar episodes, stating "*I was **petrified**, like I used to have nightmares"* (201-202). These participants had clearly faced a high level of worry and stress with their change in role.

It was also evident that despite being experienced ITU nurses, the transition into a trainee ACCP role impacted significantly on the individual's confidence. David, Anna, and Emily spoke specifically about a disconnect between how they perceived their existing knowledge, and how it felt when they became trainees. Anna recalled:

> *and all of a sudden things I thought I knew I didn't actually quite know (change in voice tone – surprised tone). Things I did know I then forgotten. And then there were some things, oh my God, I didn't even know that ever"* (71-73).

The shift in being a confident expert nurse also impacted on David, and he described:

> *I started this role, and I felt a bit disempowered I suppose, a bit underconfident. I felt like there was a lot of things that I didn't really know and understand, although you thought you did"* (201-203).

Emily distinctly remembers a time that she felt she knew nothing anymore, recalling that

> *the confidence was awful, I mean I remember about after three months sitting in the office with [colleagues] and saying I need to hand my notice in, I can't do this"* (204-206).

Despite being successful at getting the trainee role, Victoria expressed that she "*didn't see myself as worthy **at all**"* (121). She continued to consider this:

> *And I don't know if that's a personality trait, or as a female thing. We were talking about it at work the other day about, you don't get boys saying, "Oh I'm rubbish...."""* (125-126).

This perspective was reflected across the interviews, as the majority of comments about a drop in confidence or other negative emotions or worries originated predominantly from the female participants.

As well as the shift in clinical practice, undertaking the academic part of the training also generated some concerns. For Isobel, the consequences of not managing to meet academic standards was evident:

> *That was the biggest thing for me, that I wouldn't be clever enough. That I wouldn't pass the exams and I wouldn't be able to do it"* (151-152).

There was evidently a feeling of pressure that staying in the role was dependent on gaining the academic qualification. However, for others, the pressure was related to how others may perceive them if they did not complete the course. Even with the comfort with doing their ACCP transition within their own ITU, Anna and Victoria both expressed a fear of failing in front of long-standing colleagues:

> *although there is one aspect of, God that would be really embarrassing if I fail at this, I would leave then [laughs]* (Anna; 159-160)

> *I wouldn't want to stay in my own department because maybe it's a bit embarrassing* (Victoria; 386-387)

Some of the participants spoke about the positive impact of support that they had received during the transition. Having peer support from other trainee and qualified ACCPs in critical care was valued, as Frances explained:

> *So we were really helpful to each other. We were both organised in different ways and I think had either of us done it independently for the first time, we both would have struggled a lot more"* (317-319).

For Emily, the benefits of having peer support continued beyond the training period: "*And to this day now we are so close because we had an alliance together"* (213-214). However, not all participants had access to others who understood the ACCP role and the realities of transitioning into the role. Matthew remembered there was little support for him when he started, and that "*doing it alone was hard"* (179). As a solo ACCP in her ITU, Isobel sought out her own source of support from the Outreach team, who she saw as 'the closest' to her in terms of her role. Working within an ACCP team did not remove a sense of seclusion that some participants felt. For Frances, the isolation was enhanced as she tended to be on shift without her colleagues, something Anna also conveyed:

> *So, and it's a lone role and that's something I had missed. Nursing is very tight, they are very team focussed* (466).

Overall, the challenges that the participants encountered, and the variance in support reveal a picture of loneliness for the participants, despite working within what are generally large multi-disciplinary teams in critical care.

As well as having support from critical care colleagues, other advanced practitioners working within the wider organisation proved advantageous during the transition. For example, advanced practitioners in different departments paved the way for later ACCP trainees:

> *So anything with the [organisation] rules around, you know, prescribing, erm radiology requesting, she had kind of done that before. So she was a massive support"* (Matthew; 91-92).

Likewise, Alex benefitted from others who had gone before him:

> *So there is advanced practice[tioner] in the emergency department who had broken a lot of boundaries and had moved advanced practice forward. And simple things that you need for your daily working life, like the ability to request a CT, they had gone through that difficult governance point"* (328-331).

There was a recognition that the challenges experienced during the transition were ultimately beneficial in their accomplishment of becoming a qualified ACCP. Anna reflected about taking a proactive approach to managing herself, explaining:

> *So you have to adapt, you basically had to adapt and I had to honestly say the first year was probably about pulling your pants up"* (213-214).

This comment portrays a 'get on with it' approach, which Victoria also adopted:

> *You have to really embrace it. You have to be all in. I think that's what I couldn't get my head round. You need to be prepared to take responsibility for yourself and your actions"* (435-437).

Isobel concurred that self-motivation was important:

> *I think if you want something badly enough then you can do it, so I think it is about employing the right people. But yes, it's hard and there will be tears but at the end you'll be a better practitioner for it"* (440-442).

As participants found strategies and processes to help them during the transition, a shift in mindset was apparent as they adapted to a change in role and responsibilities.

Victoria recalled a situation when she recognised she was viewing a familiar nursing ritual from her new perspective. The example related to a nurse reporting information about a patient, to check if action was required:

> *Ok, I'm just going to write _____ (name) ACCP informed" (laughs). So I went, yeah you write that, that's fine. And I've done the same as a nurse, I would write Doctors informed, no action taken. We all do, we're legal eagles, aren't we? I just thought it was really funny* (440-443).

Anna also showed a degree of acceptance and even reconciliation to her changing position and role, and for the shifting of professional relationships. She explained:

> *there is no fluffy talking, there's no "Oh god I had a really shit day at home yesterday". They don't want to know. And you get that, and that is quite lovely in nursing as that helps you on your day. You don't always get that on the medical side. You have to find it. I can go through a whole day of not talking to medics about anything but something very clinical* (470-473).

Sub-theme 2: Praxis – being a nurse

This sub-theme concerns itself with how the participants perceived their professional identity in relation to being a registered nurse working in an ACCP role. Within all the participant interviews, the importance of being – and remaining – a nurse was apparent. This was conveyed in varying ways, including through expressing their thoughts, values, skills and behaviours which underpin their nursing heritage.

All of the participants affirmed that they were still a nurse within their ACCP role. Several participants were particularly explicit in clarifying their professional identity. For example, Emily made it clear that "*I truly believe I am a nurse"* (331), with Frances similarly confirming "*I still very much feel like a nurse*" (438). The phrases 'truly believe' and 'still very much' appear to add a strong emphasis to their statements, thus revealing the extent to which a clear nursing identity is still held. As discussed earlier during her interview Anna had spoken of some challenges to the positioning of her ACCP role by others. Describing being a nurse as the "*core of who I am"* (382), Anna asserted that she "*wouldn't want to give up that nursing side"* (340), therefore highlighting her own contrasting perspective.

Alex was mindful about the differing perceptions of nurses working in an advanced level role, asking: "*What does it actually mean, what are you actually doing?"* (161-162). He summed up his own view, stating "*You know, we are maxi-nurse not a mini-doctor"* (275). This example recognised the conflicting descriptors of advanced level roles, which have been evident in the wider literature. Alex's comment

substantiated his view that his ACCP role was enhancing his nursing practice rather than replacing or substituting for a medical role.

In a similar way, Matthew also placed himself as remaining a nurse who is an ACCP:

> *…. in my nursing role, if you call it that, you know I am still a nurse, but just as a way to make it different (pause)* (175-176).

Matthew seemed to want to substantiate his meaning as he was initially talking about his former nursing role, and in doing so he reinforced his continuing identity as a nurse. Similarly, Isobel recognised the importance of her nursing roots now she was an ACCP, explaining:

> *I think as a person you do change a little bit, but I think my values have always stayed the same. And I don't think I've ever forgotten where I've come from* (242-244).

Drawing on nursing values, such as caring, empathy and having a patient-centred, humanistic approach was evident within the participants new ACCP role. Alex spoke of the importance of building a rapport with patients and their families, something he saw as key in providing "*supportive care to the family and the patient"* (119). Isobel described how:

> *they* [the patients] *wave to me in the morning when I come in when they are awake, and they wave to me when I go out in an evening. Again, that's just the humanity, that's just me* (411-413).

An interpretation of these extracts is the importance of having a professional, caring relationship with the patient and their families, expressive of the therapeutic and holistic nature of nursing. For Alex, he was clear that:

> *we are ultimately there to care for the patient whether that be fundamental, essential care or whether that be complex stuff like procedures* (385-386).

This statement shows the contrast between the caring element typically associated with nursing practice, and the complexity of practical or procedural interventions typically associated with medicine. Alex's comment highlights that the ACCP role should encompass both of these extremes. Matthew also spoke of combining the two paradigms of nursing and medicine within his developing ACCP role. He recalled:

> *in my very early days I did a central line on an awake person and after, the nurse who was with me said, erm, what was it, 'That was really good, you did it in a really nursey way'"* (244-246).

Elaborating on this, he had interpreted this comment to mean "*those skills of being able to talk to a patient and engage straightaway and gain their trust which I think you learn as a nurse" (247-249)*. David added to this point, recognising:

> *it's your approach to patients. I think we're a little bit more [pause], have more empathy than our medical colleagues. It might be that I tend to listen and sit with patients and hold their hand and talk to them rather than just like, go in, quick check, come out* (337-339).

Although David struggled slightly to find the word he meant, he determined 'empathy' as a core element he brought as a nurse to his direct clinical practice as an ACCP.

It was evident that participants felt a degree of empathy for the nurses in the bedspace too. Isobel saw it as important that "*I'm very respectful of the nurse at the bedspace because I've been that nurse at the bedspace"* (244-245). Isobel conveyed a sense that she appreciated that she had gained an opportunity that others had not, and that perhaps in other circumstances she could be the nurse in the bedspace still. Remaining empathetic to their nursing colleagues, both Isobel and Anna recognised a level of frustration that nurses experienced, which they could help with as an ACCP. Anna explained that "*It might be nice to put the chest drain in, that's the sexy side of it" (*384) but she countered this:

> *there is still the delirious patient that ……, and I've clocked that and I can see it, I can see the frustration of the nurse* (395-396).

Anna was very vocal during her interview about what she viewed as the essential nursing foci of her role. This was evident with her use of the word 'sexy', used several times to describe the more complex and medicalised procedures that she felt were favoured by some ACCPs in her team. Conversely, she referred to her role as "*scooping up the nitty gritty"* (256), which referred to elements of care that help the nursing staff care for the patient effectively. David also recognised the impact of being able to show the "*little things, you know, communication, the empathy, understanding what my nursing colleagues are going through"* (341-342), but was assured that:

> *the nurses, when I am working with them, they can see that a little bit, and you know it's why they find us more approachable* (343-344).

For most of the participants, being approachable to other nurses was a key factor they strove to maintain during their transition into their ACCP role. Participants gave examples of providing hands on

care, which suggests a willingness to support the bedside nurse, as well as ensure the patient is cared for too. Emily explained:

> *if someone says, "'Can someone give me a quick hand rolling?", and I am sat at the desk, I am not going to ignore that* (315-316).

Similarly, Matthew stated:

> *I still made sure if they needed turns, or I'd cover a break if I could, or I'd help them to do their IV's, and I still do* (192-193).

Several other participants also confirmed a similar stance to helping nursing colleagues directly, making the point that this was very much in contrast with what their medical colleagues would do. Alex explained this further:

> *if I'm at a bedside assessing a patient and the patient has had their bowels open, I will help the nurse roll the patient and help the nurse do, erm, you know, fundamental care which I think traditionally doctors would not do. You know, it would be like, "Well clean the patient then give us a shout" (smiles)* (381-384).

Whilst assisting with nursing care could be viewed as a mechanism to ensure good relationships with the nursing staff, the sense conveyed from the participants was that they recognised the patient needed care which they could provide. For Anna, it was a clear opportunity to convey that her ACCP role was a product of her previous nursing experience:

> *So yeah, my experience is not two years in training as an ACCP then just post qualifying as an ACCP. I've got 30 years in ITU that I can share with the ITU nurse"* (348-349).

As the following extract shows, Anna was confident in expressing how her nursing knowledge manifested in her practice to support both the patient and nursing staff:

> *……the medic may come along and assess the patient for respiratory failure, assess and go, "Well we have got poor air entry here". I'll look at the patient and go, "Well they will because the nurse has got him at 25 degrees on the bed. Let's sit him up, let's get him up the bed, let's get him doing a cough, lets change those tapes* (360-363)

It was evident how important it was to support nursing colleagues with direct clinical care if required, thus reinforcing their nursing heritage and promoting their ACCP role as requiring nursing knowledge and skills. However, there was a sense of needing to keep some control to balance the desire to help

within the confines of their other role commitments. For example, Alex explained that he aimed for a position "*where they don't feel that they can't ask but they also don't get upset when you say no"* (399-400), adding "*So yes, it's a balance between the two"* (406-407).

As registered nurses, all the participants currently working in their ACCP roles need to remain registered with their original regulatory body, the NMC. However, it was clear during the interviews that this was not viewed negatively or seen as a cause for concern. Some of the participants reinforced their identity as a nurse through the explicit acknowledgement that they wanted to remain regulated by the NMC. The context for this relates to wider national deliberations that some advanced practice roles, such as ACCPs, could become distinctly regulated by a medical body, such as the General Medical Council (GMC). Both Anna and David portrayed a reluctance for this to happen:
"*I'm very comfortable still being registered with the NMC"* (Anna; 340-341)
"*I think with regulation I'd like to stay in my own base profession, definitely"* (David; 332-333)"

Remaining a registered nurse with the NMC requires formal revalidation of practice every 3 years to maintain their registration. Alex used this professional requirement as a way of reinforcing his nurse identity to his nursing colleagues, explaining:

> *we ask one of the senior nurses to do our revalidation with us, because it is important for them to realise, we still do five reflections, and we still do nursing elements, and we still are part of their team* (374-376).

Alex's experience appears suggestive that his nursing colleagues did not appreciate that his fundamental nursing identity and professional status remained as he moved into his ACCP role. His use of 'still' three times in this extract particularly underlines his experience of not being recognised as a nurse, something that appeared as a pattern across other interviews. Isobel moved to a new Trust as an ACCP and recalled the challenges of establishing her identity in a team that had not worked with her before:

> *I think because they have never seen me as a nurse, they just see me as _____ (name) the practitioner, and they are like "But you can do everything" and I'm like "Yeah but I'm still a nurse* (379-380).

In this situation, there appears to have been a judgement made that the new role was a medical one, a misconception that Isobel was keen to correct with her new colleagues. Anna also spoke of junior nurse colleagues who did not appreciate her heritage or experience. Appearing bemused by this, she recalled offering to support the nurse with help for a patient, to be told: *"Oh, you won't know how to do this on*

an ITU patient," "Oh, no no we do (laughs), I'll tell you now we do" (282-283). Across the interviews, it was apparent that the participants remained rooted to their nursing identity and sought opportunities to apply and promote this within their ACCP practice.

Sub-theme 3: Establishing a sense of belonging

Despite experiencing personal and professional challenges during their transition, participants demonstrated perseverance in working towards getting their ACCP role embedded into the wider team. Participants demonstrated a range of strategies and approaches as they sought to establish their positionality, and to have their advanced role accepted.

Being positioned between, or perhaps within, both a medical and nursing team was viewed as an advantage for some participants when it came to building new professional relationships. This positionality was described in different but similar ways. Considering her own ACCP role, Victoria expressed "*I feel really privileged that I do work both sides of the fence, so to speak"* (402). In this extract, Victoria's choice to use 'fence' to describe the space between the two professional groups suggests a barrier or boundary is in existence. Other participants offered a different perspective. For example, Matthew and Isobel described themselves as being 'a bridge' between doctors and nurses, suggesting the ACCP role was a more of a conduit between the two professional groups. Isobel explained:

> *you are almost a bit of a bridge in some ways erm, between the nursing staff and especially junior nurses, they are more likely to come to you than speak to somebody senior on the unit, from the medical point of view* (250-252).

This comment suggests that the ACCP has a facilitative position, enabling nursing staff to feel confident to raise a concern or query, an experience reflected across other accounts. Anna had noticed that nurses explicitly chose the ACCP when seeking help:

> *that junior nurse developing, and those that are underconfident will call for help and actually they will call the ACCP first before they call the registrar now* (368-369).

David also found this in his experience, saying:

> *it's nice in a way because they are putting their faith in you, and you know they trust you more than others, rotating through doctors* (260-261).

David's use of 'nice' in this extract is suggestive that he gains positive validation from being trusted in the way he describes. Victoria put it quite succinctly when she discussed her role, saying: "*I do love that I recognise that Ah, that's a problem, how can we fix it?"* (396-397).

It was evident that the ACCPs sought ways to support and build positive relationships with the nursing team. Creating a sense of trust and collaboration was achieved through being a familiar and known part of the ITU workforce. This appeared to be enhanced by providing a constant and permanent presence in the team, in contrast with the rotational nature of medical staff. In addition, across the participant experiences, strategies and activities emerged which underpinned how they ACCPs facilitated the nursing team, thus enhancing their own sense of belonging. Using their nursing expertise, in conjunction with their ACCP knowledge and skills, participants discussed how they took opportunities to support and teach nursing colleagues. Anna described how: "*you are educating the nurse at the bedside with what's going on with the patient"* (31-32). Similarly, Victoria expressed that:

> *So there's a lot of nurture and nature, and "Do you why we are doing that?" So we assess a patient and make a plan for the day, so going through that plan and just double-checking "Do you understand why we are doing that?" "If not let's discuss it and make sure you know what I'm doing and why I'm doing it"* (94-97).

Using negotiation and education to engage the nursing staff was an approach David had to take on occasions to reinforce his authority to initiate the patients care. He elaborated: "*you work through the problem with the nurses and say, "Well no, I want to do this, and this is why"* (273-274).

Whilst also positioning his ACCP role as a bridge between nursing and medicine, Matthew viewed this in a more conciliatory way. He recalled being told by the nurses that he was "*now their bridge to the doctors"* (188-189). Elaborating on this point, he explained:

> *so I would sometimes you know, be called up on as a bit of a buffer between the two (laughs) if there was conflict"* (190-191).

Although Matthew laughed when recounting this experience, there was a sense that being put into that position could become challenging. David also experienced being asked to mediate between the doctors and the nursing team at times, explicitly remembering being requested to second check a doctors plan for patient care:

> *And if something does not sound quite right and things like that, they'll say "What do you think?", "Do you think this is ok?"* (261-262).

Anna appeared to take a more middle-ground position, defining herself as being a "*wonderful hybrid that comes together between the two"* (37-38). Describing her role as "*understanding both parts"* (359-360) of the team, she indicated that being able to recognised and smooth down irritations between professional groups as part of her role. She gave an example of this:

> *nurses are very used to, on ITU, giving something at six o'clock, two o'clock and ten o'clock. Electronic prescribing could do five past four in the morning, and could do ten to three in the afternoon. Well, that doesn't sit well with an ITU nurses' brain (laughs) and I can see why. But the medics will just do whatever, so, you know, whereas the nurses know they can come to us to alter that* (260-263).

It appears that for some participants, being seen as the 'go-to' person for problem-solving supported the building of trust and collaboration between the ACCPs and the nursing team. However, some participants found it more difficult to establish themselves. Alex spoke of making a concerted effort to build better relationships with his nurse colleagues, who he thought saw his role as a threat in some way. As he recalled his experiences, he repeated the word 'hit' on several occasions when discussing his strategies for trying to establish himself as still having a nursing identity. He described how he: "*tried to hit it from lots of different ways really, erm to try and get them onboard"* (272-273). Acknowledging that it took "*about a year of heavily investing"* (276) before a noticeable improvement was seen, his description of this experience as being "*quite uncomfortable at times*" (263-264) appears to be an under-statement which does not reflect the potential challenges he faced.

In addition to establishing a sense of belonging within the nursing team, participants recognised the need to also find their position and identity within the wider multiprofessional team. One strategy evident in the accounts was the provision of education and support for doctors, particularly junior doctors who underwent a fixed term rotation to ITU. Isobel explained:

> *the F1 and F2s on the unit felt that I'd prevented them from making a lot of mistakes and was kind of already supporting from their point of view to a very daunting area for their training* (335-337).

Anna also found that the junior doctors were fearful of asking questions, showing empathy for them as novice learners within ITU:

> *The junior doctors usually come up to an ACCP and go either, "Thank god you are on today" or, "I am so glad you've asked that question because I didn't know the answer but I never would have asked* (250-252).

Although neither Isobel nor Anna expressed that they understood how the doctors felt, there appears to be a recognition that they were also undergoing a transition during their own training situation.

Some participants were very keen to promote the visibility of the ACCP role outside of the ITU.
As well as pro-actively engaging his ITU colleagues, Alex extended this strategy outside of the ITU as well:

> *the hardest element of getting people on board, inside and outside of the unit, erm, and not proving the role but supporting the role and being positive about the role and being an advocate for it, an ambassador as well* (359-361).

David agreed, and ensured he was: "*getting yourself known, and what the role is"* (240-241). Victoria found her role was more recognised in the wider Trust, particularly as she proactively promoted herself:

> *I always make a big point of wearing my name badge because I really dislike the whole "Excuse me, sorry I don't know your name". So if it's on your chest, right away it's no problem. People will be like _____ (name), and obviously it sticks after a while. So we are getting out there and people do recognise us* (327-330).

These strategies conveyed a sense of role modelling employed to ensure the ACCP role was recognised and accepted. For most participants, they spoke positively about being in a much more positive place in terms of their identity and professional positionality in their ACCP role, than when they first commenced their transition. For Isobel, becoming accepted as an ACCP appeared to be a sensitive memory for her, as she hesitantly recalled:

> *It has taken me a long time to be ……. accepted and …… proven that I am capable of doing the role* (38-39).

Emily and David both also spoke of being accepted and getting respect for their roles. Emily reported a significant shift in the perception of the role, stating: "*they've got the respect for me now and I've gained credibility"* (276). Similarly, David recognised that he needed to not only gain the ACCP qualification, but also that getting the respect from the nurses and Consultants who "*love us to bits now*" (24; 26)

ultimately validated his place in the team. David's sense of place and empowerment was further illustrated through his maturity in his ACCP role:

> *a lot of consultants that I work with have been my trainees [laughs]. So I've come through and I've shown them how to put central lines in and now they are my consultants* (246-248).

GET 3: "I think it will get better, won't it?" - vulnerability, concern and hope

> *"So yeah. I think it will get better, won't it?"* (Emily; 259)

The third theme reflects the thoughts and experiences expressed by the participants in regard to the future of the ACCP role. Consideration of their own career options as well as career limitations emerged. Participants were thoughtful of how future ACCPs might experience a transition into the role, suggesting a level of protectiveness for the individuals. Protectionism also extended to the standards of the role, from education preparation to the implementation of roles. There was a particular concern about organisational governance and understanding of the role. The need for strong leadership for ACCP teams was evident.

GET 3 comprises of two sub-themes: *An uncertain future; The need for role governance and leadership.* In addition, a short summary of findings related to participants experiences of being an ACCP during the Covid pandemic will complete this section.

Sub-theme 1: An uncertain future

Across the interviews, consideration towards nurses who may come into ACCP roles in the future was evident. For some participants, this appeared to stem from their own transition experiences, suggesting a level of protectiveness towards the role, and towards other trainees or junior ACCPs. An example of this was evidenced by promoting to potential ACCPs what they should consider if thinking of moving into the role. Emily appeared to have clear expectations of potential ACCP trainees. She explained:

> *So it's a commitment really of, you know, not that they just fancy it, or you know, or you're going to be an [Band] 8a in two years. So yeah, commitment is a huge thing"* (351-352)

As she spoke of the need for commitment, Emily used phrases such as 'immense' (competencies), 'massive (education) and that the training was a 'huge thing' to underpin the significant demand the role would have on an individual. Similarly, Anna offered a word of caution for others, warning that

nurses should not consider applying for the role if they were "*a bit disgruntled or a bit bored"* (451). Elaborating further, she advised that:

> *it's got to fit in with your personal life, because the university side and the two years of FICM portfolio is not easy. It's a slog* (456-457).

Anna's description of it being a 'slog' appeared to relate to the frustrations she had expressed regarding her early transition period. Certainly, her words imply that a potential ACCP would need to be highly motivated to make a successful transition into the role. Alex was keen to show others the reality of the role by having them spend time with him, providing insight into the reality of his ACCP role. In doing so, he found that some colleagues had not appreciated the breadth of the responsibilities of the role. Summing this up, he stated:

> *So yeah, it's giving them an understanding of that as well and actually it is great when people have the awareness that it may not be the role for them* (451-453).

Alex's comment of it being 'great' if someone does not want to proceed to apply for the role implied a sense of gatekeeping. This was also reflected elsewhere in the interview as on several occasions he referred to the importance of being '*the right candidate*' (201; 240) or being '*the right fit*' (192-194; 201) for the ACCP role.

Participants commented on the importance of developing knowledge and skills that related towards all four pillars of advanced practice. Anna advocated this, stating that:

> *you talk about these four pillars, and what advanced practice is, and you do have to practice those four pillars. I think if if you say I don't do much of that, I only do some of that (counts off on hands) well, I have to argue that you are not encompassing all of the role* (44-47).

Anna's comment highlights the dominance of the clinical pillar for some in advanced level roles, which Matthew also acknowledged: "*initially I was very task-focussed, you know, I wanted to do the central lines because it was new, it was exciting"* (108-109). Recognising this tendency, he spoke of how he now ensures that trainees realise the potential breadth to the role and not just focus on the clinical pillar elements. He appeared particularly keen to promote the need to diversify the role:

> *I'm telling the qualified ones who've come through, you've got to do other stuff. You've got to find other ways because you're going to get bored* (273-274).

Matthew's suggestion that ACCPs could become bored or possibly unfulfilled in their role resonated with other participants who expressed concerns about the career options ahead. All the participants were established as a qualified ACCP, and some spoke of their professional aspirations. Isobel had considered her long-term goals, explaining:

> *I think eventually Consultant ACCP would be nice, in that I can see patients on my own and stuff in clinic, and you can progress from that point of view with a nice big team that covers Trust wide, with a full rota, that would be lovely (smiles)* (458-460).

Isobel's aspirations gave a sense that she saw a move from her more controlled and solo ACCP role she had spoken about. She was able to articulate the benefits she saw for having a team who were active in promoting research, education and leadership through service improvement work. Matthew also had a distinct goal in mind for his future role. However, he spoke of a lack of career opportunities in his region:

> *I was looking for a critical care consultant post but in [region] there are zero. All of the money's gone, it has been clawed back as people left* (279-280).

This comment suggests that vacant posts were not being advertised or recruited to, leaving a reducing opportunity for individuals to progress their career. The potential impact of a lack of career opportunity was further explained by David:

> *There are a lot of units that are struggling I think at the moment, they've got a lot of experienced ACCPs. Some have been around for ten plus years now or getting up there, and they can't see a career structure for them at the moment, which is a bit, um, a bit frustrating, I think* (221-223).

This frustration resonated for Matthew as well, who showed concern for upcoming ACCPs:

> *if you are going to be in a junior doctor role for the next, well, who knows these days, 20 plus years. Actually, a lot of my younger colleagues could be doing this for another 30 years"* (275-277).

Matthew's description of ACCPs being in a junior doctor role should be taken with caution. His narrative during his interview was less about the positioning of ACCPs but rather about being in a role with little or no career opportunities. An interpretation of this extract is that he is suggesting that junior doctors would not expect or be expected to remain in the same role without progression for so long, thus highlighting a degree of unfairness for the ACCPs.

Despite these issues, it was seen that there was longevity for the ACCP role as an option for critical care nurses, although Anna recognised there was still some uncertainties around it: "*I think it will be a role in ITU now. It's just what it morphs into in time"* (62). Using the term 'morphs' to describe a process of change or transformation, Anna appears to suggest that the role has the potential to evolve in terms of its scope. Interestingly, Anna had been one of the more vocal participants to highlight the need to keep control of the role as well as to manage the expectations of others.

Other participants also recognised that the scope for the ACCP role in the future would remain controlled by the employer. David spoke about additional training and competencies that ACCPs could do:

> *I think these optional skills frameworks will become part of ACCP competency in the future as a basic competence, but it is just developing that. Some trusts won't want it"* (85-86).

David was highlighting the marked differences in the ACCP role that could be apparent if there was a varied approach to the scope of the role, suggesting some ACCPs could be afforded more development than others working elsewhere. He later described the curtailment of professional development opportunities as a "*two-tiered standard"* (91), although he remained optimistic that change "*will happen"* (94). Frances' own role development opportunities also appeared dependent on the expectations (and permissions) of consultants. Referring to the FICM optional skills framework for advanced airway management which would mean she may be expected to intubate a patient, she considered "*I think it that is something that will probably come"* (17-18), adding "*I think they would be happy to support us doing that"* (19). In contrast to Davids confident stance for role development, Frances' repeated use of 'I think' portrayed a less certain view of her future role parameters. This sense of reticence was further reinforced with a subsequent remark describing how "*I'm certainly somebody who will not necessarily fight for every procedure"* (429-430).

As qualified ACCPs, participants referred to their commitment to support junior or trainee ACCPs in their team. The need for an improved national approach for future trainees was suggested by Alex, who spoke of the problems associated with the transition into the role experienced across the country. He viewed FICM as having a responsibility to mitigate some of the common concerns:

> *So I think FICM need a bit more, erm, more guidance for people who are going into the role. And then also a bit more about transition. And then also a bit more about the career pathway afterwards* (463-465).

He appeared cautious that this would improve "hopefully long-term" but recognised that his own transition and positive achievements in the role would help to shape others. An improved experience was also noted by Anna. It was apparent that the support and opportunities the current trainees in her team have, which differed significantly from her training period. She acknowledged:

> *So they are in a better place, our trainees are, and to the point where I am actually jealous of them (smiles and laughs)* (502-503).

Victoria recognised the responsibility she had towards ACCP trainees in her team, shaped by her own transition experience, explaining "*the next lot coming through will feel a good bit more supported. More of a wall to lean on"* (461-462). Describing the qualified ACCP team as 'penguins' who would "*huddle around and help to support and protect"* (456-457), she conveyed a sense that the trainees needed some form of defence or shielding from challenges or unpleasant experiences. Referring to his junior colleagues fondly, David presented what could be viewed as a paternalistic view of his "*two little ones [laughs]"* (112), explaining that they were "*starting to sort of fly the nest a little bit"* (251). However, he did express some concern that newer ACCPs may be less resilient as they had not faced as many difficulties as he had. He further explained that:

> *if they came up against a challenge in the future, you know, someone doesn't know what their role was, I think they might find it difficult, a bit of a shock* (283-285).

Alex also had concerns for his junior colleagues but for different reasons. He spoke about the potential impact of recent social media posts[3] which had escalated in volume and seriousness:

> *So some of my colleagues really get affected by what is on Twitter and what has recently been on Twitter about inter-professional arguing, I think, for want of a better word, about how advanced practice is perceived by some people that are very, very cruel in certain forums* (472-474).

This extract reflects his view that advanced level practice is not fully recognised or accepted across differing professional groups. Alex stressed the significance that this type of external factor could have on the trainee's transition experience, summarising their view:

> *Gosh, do I really want to qualify in an environment where there's people openly hating us and being unprofessional about us?* (480-481).

[3] This relates to an increasing volume of social media posts by doctors, expressing contemptuous and disparaging remarks about advanced practitioners and physician associates.

Alex's concern illustrates a degree of vulnerability experienced by nurses moving into an ACCP role, with many contributing factors discussed by the cohort of participants. Anna recognised that increasing and widening demands on the ACCP team were at the core of the issue. She cautioned the need for "*careful thinking"* (175) about the role, adding: "*we are in danger of burning ourselves out being something of everything as an ACCP"* (373-374).

Sub-theme 2: The need for role governance and leadership

Participants showed a level of concern regarding the organisational governance and recognition of the ACCP role. Their expectations and experiences with direct and wider leadership was also explored.
It was evident that participants displayed a level of protectiveness regarding the positioning of the ACCP role against other advanced level roles. In addition, there was also a sense that the participants felt it necessary to act as a gatekeeper for future ACCPs.

Isobel found that she needed to be clear about the distinction between her ACCP role, and that of other ACPs in the wider organisation. She recalled: "*So, they were wanting to refer to me as the ACP for intensive care. I'm like "No I'm not an ACP, I'm an ACCP"* (344-345). As a solo ACCP in her Trust, Isobel conveyed a strong need to assert her professional identity, describing her role as being a "different breed altogether" to that of other advanced level roles (348). Presenting a clear distinction between the preparation of the roles, she explained:

> *some of the ACP training is not the quality of the training what I had. And obviously going forward for when I do get trainees, the training needs to be similar to what I had, not what they get as an ACP* (349-351).

This statement illustrates that for Isobel, the knowledge and skills required for an ACCP role are different and are seen as being more complex that is required for other advanced practitioners. This was a view held by David, who also spoke about the quality of the educational preparation for the role:

> *Obviously, a lot of courses now are developing just pure ACCP courses, to be quite specific because I think the skillset and the knowledge probably needs, well I'm being a bit biased here, probably needs to be a bit higher than a standard ACP* (103-105).

David went on to acknowledge that two medical bodies – FICM and RCEM – both had approved standards for the education and training of their specific advanced practice roles, although he also recognised that currently not all ACCPs would have completed a specialist FICM accredited course.

Nonetheless, he spoke confidently to explain why he felt it was necessary to ensure ACCP education and training standards were upheld:

> *So an ACCP in Birmingham is the same as an ACCP in London and Newcastle, and we've trained to the same level* (70-71).

This appeared to be an important consideration for Alex as well. He recalled seeking a FICM approved ACCP course specifically for his own training. He explained that he felt it would add "*rigour to my training, for patients and for me"* (190-191), as well as offer some longevity and credibility to his professional practice, particularly if he moved to another organisation.

Common to these accounts was a sense that there could be a marked difference in the qualities of the ACCP post-holder, a concern shared by Frances. Speaking of the challenges in trying to recruit and grow the ACCP team in her ITU, she explained:

> *So there is such variation that you know you could be employing somebody on a qualified basis. But actually, when they come, you could go, "Oh my goodness. You know this person needs six months supernumerary and a lot of supervision." It's the risk you take, isn't it, with employing from elsewhere* (112-115).

David also spoke of risks to the organisation with the ACCP title and qualification, in that:

> *you could work in that role and not have done the competencies and call yourself an ACCP and there's nothing you can do about that* (319-322).

Expanding on this point, he offered a degree of caution about the challenges of unregulated role titles, giving an example from his own Trust's Electronic Staff Records (ESR): "*there are lots of 'advances' and they can be Band 2 or Band 3"* (422-424). David's example highlights the importance of organisational governance for advanced practice roles, a point discussed by several of the participants. Matthew was keen to point out that in his experience:

> *there's a lot of issues in the early days about governance and what we do. And actually, still is* (167-168).

Explaining this, he described a lack of organisational readiness or recognition of the ACCP role. As one of the most experienced ACCPs, Matthew conveyed a clear sense of frustration that the issues and problems he has with getting his role recognised and accepted has been going on for "*best part of a decade"* (169). Underlining this point, he expressed that "*it's as if people are finding out about us for the*

first time" (231-232). David was vocal about how a lack of understanding of the role within the organisation had led to issues with further promoting or developing the role. Despite his role being one of the earlier ones in the region, he was concerned that there had been a failure to keep up with other employers who were actively growing the ACCP workforce:

> *So you know local Trusts around us now, you know have got huge teams, you know teams of 12 and 15 people. Different trusts pushed ahead. So, from being ahead, we've sort of fallen back a little bit* (35-36).

At the time of their interview, Emily and David's employing organisations had a vacancy for a Trust lead for advanced practice. Both appeared to be positive about the benefits this role would have in improving governance and standards. Emily explained:

> *I think the corporate ACP lead will be brilliant for that, as long as it's the right person, as they should actually put everybody under the same umbrella and have the same standards* (325-326).

Similarly, David felt the new lead role would be an opportunity for change, hoping the person would look at "*communication and staffing and retention and you know quality"* (405). He spoke about how he was currently proactive in taking opportunities to engage with his Trust executives and senior level colleagues to promote the role, during advanced practice forums:

> *We get the Chief Nurse to come, we get the medical director to come, the chief operational officer, have a little chat to say this is what we are doing* (400-402).

Participants were clear that leadership for ACCPs was important, both at a strategic level as well as a more local or direct level. Some participants had a senior or Lead ACCP. In Emily's case, she was in the position of leading other ACCPs. She spoke positively about the leadership she experienced as a trainee and into her first post. Becoming a Lead ACCP allowed Emily the opportunity to role model behaviours and approaches that she found helpful and impactful. For Emily, being a leader meant being available to her team and having clear involvement and responsibility to ensure they progress through their transition and beyond. She conveyed a positive and supportive approach to her team, making sure "*I do have a day with one of my trainees at least one day a week"* (61-62). She also actively ensured supervision and support was given:

> *if their consultants, it's their ITU week, my guys will work the entire week, so they are having 1 on 1's* (224)

However, other participants did not have such positive experiences of leadership during their transition. Anna recalled that:

> *We didn't have an ACCP lead, we had another manager within our service who ……, what's the word, ... the only vision that individual had (laughs) was the fact that it ticks a box that we have ACCPs in training* (191-193).

Anna appeared to struggle to find the word to describe the individual she referred to but this extract implies a situation that was not conducive to good leadership. This was highlighted through the phrase 'ticks the box' which conveyed that she had a leader who was not fully invested or involved in the ACCP role. Matthew's experience of leadership for his ACCP role was also challenging. He was clear that this was "*because it doesn't fall in a neat nursing role or medicine role, they often don't really get it"* (232-233). This was further explained as result in a change in how the ACCPs were positioned in the wider team. He reported that initially he was managed within nursing, but:

> *a new nursing manager has come in who doesn't really get ACCPs, is trying to give them to the doctors to manage* (211-212).

Matthews comments confirm a lack of understanding of the ACCP role by the senior nurse managers, a view echoed by Frances. She explained that the consultants appeared to want to move away from the management of ACCPs, something that appeared to be a concern to Frances:

> *The nursing structure isn't great for managing us, to be perfectly honest, because they've* ***absolutely*** *no idea about our role* (146-148).

An alternative would be to have a Lead ACCP, but again Frances's comments revealed some anxiety about this:

> *it feels if we have a senior ACCP who is, you know the band above us, it very much puts a ceiling on the rest of the team's development* (156-157).

Reflections of the COVID-19 pandemic

During the individual interviews, some participants spoke about their memories of working in critical care during the Coronavirus disease (COVID-19) period which was particularly impacted on during the national lockdown periods between March 2020 and December 2021 (Institute for Government, 2022). The impact of the pandemic on critical care was unprecedented and had significant impact on the volume of patients requiring admission, and how ITU's were organised (Endacott et al., 2022).

Participant recollections comprised of a mix of positive as well as negative memories and experiences. Whilst this element of the individuals lived experience did not constitute a personal experiential theme for any of them, during the cross-case analysis process, I repeatedly was drawn back to the collective and shared experience that the participants had gone through, which I reflected on.

Excerpt from reflexive journal:

March 2025 - my data analysis work is coming along. But I am now aware that we have reached the five-year anniversary of the first lockdown. For myself, the memories associated with this time came flooding back as news items prompted us to recall that awful time. Pictures appeared on social media – nurses reminding us of the challenges of working in full PPE. In particular, one of the participants posted a memory and image of working in such conditions. As a (former) critical care nurse, I knew people enduring the pressures and stressors the pandemic created. As a mother of a child having to be schooled at home, and as wife of someone who had to go out to work every day, my own memories of the time came to the fore, and I was mindful of these.

I have been unsure what to do with the memories and experiences regarding Covid. I thought that it is not a theme as such in relation to the overarching GET, but perhaps it is. I returned to the research question which seeks to discover their lived experiences, for their role – and as such, I knew that recognising the collective experiences and the impact of these was necessary.

As the impact of the pandemic became known, Victoria and Frances were both deployed back into the general ITU nursing team. As a qualified ACCP, Frances conveyed a strong sense of frustration that she had been moved out of her role, explaining that "*it was the whole process of it, it was quite unpleasant" (*481). Frances explained that this decision appeared to have been made without the agreement of the Consultants who "*actively tried to reverse it ……. without option to"* (497). Positioning herself and the other ACCPs as senior nurses, she conveyed that:

> *we were very much treated very poorly, you know, as a group of senior nurses, we weren't treated in that way at all* (482-483)

and that:

> *they didn't see the value of our role and from a personal perspective, we didn't get out of it what we could have done* (511-512).

Frances switched between speaking only about herself and a 'they/ we' narrative when remembering her 'personal perspective', something that was quite noticeable during the whole of the interview when discussing her role and that of the other ACCPs. In contrast, as a trainee, Victoria remembered that:

> *My training was interrupted actually, I had to go back to the floor. That was fine, for months, and I didn't mind that all* (413-414).

It could be concluded that by 'not minding', Victoria felt some relief to be changing her role back to a nursing role. This could be because she felt more confident and comfortable in a role she had done for a number of years. However, during this time, she recognised a change in herself as her confidence improved:

> *it was about keeping calm and rehearsing it to them [ITU nurses]. I think maybe where it's helped with some breakthroughs. For me as well, it's helped my confidence probably, getting away from the Oh no I'm not good enough* (341-343).

Anna was also a trainee during the onset of the pandemic. She remained in her trainee role but recalled a change in how her development progressed:

> *It was a great time for learning skills. If you were a bit wobbly putting a central line in, you weren't at the end of the pandemic. You saw every complication in a shorter period of time (laughs) than you would have done otherwise. So you probably gain that skill a lot quicker* (231-233).

However, she noticed a difference in how the ACCPs and the medical staff worked during this time:

> *they* [the doctors] *were only coming onto the unit when they were needed and were in the back office. And we started to get a bit disgruntled because I was thinking but I'm never leaving that unit. I am on it the whole time. I'm helping with breaks, with rolls, with proning. We led all the proning in the pandemic, and we did all the transfers in the pandemic, the ACCPs* (375-378).

Remembering this situation created mixed feelings for Anna regarding her learning and progress, as she felt "*on one hand I am grateful for that"* (235). This contrasted with Frances, who found it challenging to restart in her ACCP role after her redeployment: "*we've not been doing our ACCP role. So I felt a bit stupid for a while"* (517).

Alex remained in his role, as did his trainee ACCP colleagues, but the change in learning opportunities did mean the trainees were delayed in being able to fully complete and transition into a qualified role. He explained why this was the case:

> *some of our trainees finished during Covid and everyone was very good at managing Covid. But Covid is very much a one pathology illness, and you follow pretty much a recipe-book of treatment for Covid. And actually that does not reflect the broad admissions of a general*

> *intensive care, a busy university hospital general intensive care unit. So some of our trainees who finished at Covid or just before Covid have probably taken longer* (48-52).

Alex was very empathetic to the challenges faced by colleagues and was keen to stress this was a reflection on the situation caused by the pandemic. Matthew had a briefer explanation, simply saying that "*Covid sent everything a bit wonky"* (106). He did not elaborate on his own experiences specifically but spoke of supporting the wider team "a*nd in that Covid time, all of us just did whatever"* (194).

As the only ACCP in her ITU, Isobel also remained in her role albeit she described working almost double her usual contacted hours at the peak of the pandemic. Modestly, she stated "*Erm, yeah, that's (shrugs) just what you had to do"* (305-306). Describing her key role during this time, she recalled having "*a lot of responsibility to make sure everybody knows where things are"* (309-310), particularly "*with ITU nurses managing more patients than they really should have been"* (311). Isobel's comment sympathetically recognised the change to normal nursing practice during the time.

Likewise, empathy for her nursing colleagues was evident in Anna's account, as she put her own recollections into some perspective: "*I still think we had an easier time than the nursing staff did"* (378-379). Whilst Emily and David did not explicitly discuss their own experiences of working in ITU during the Covid pandemic, it is reasonable to assume that some of the challenges faced by the other participants may have been evident for them as well. The impact on the healthcare staff working directly with the high number of critically ill patients was well-documented in professional and news resources. Poignantly, Matthew captured the reality of this from his experience when he was explaining some of the reasons for his decision to leave his ACCP post:

> *So Covid was a biggy. Three colleagues died. But, yeah, you know if you are around long enough you just know a lot of people, so it's going to happen* (307-309).

This relatively simple statement about his colleagues resonates with what is known about the impact of Covid, particularly Covid-related deaths amongst healthcare workers. As such, I have realised it was essential to allow the voices of these participants and their experiences to be heard.

Chapter summary

The cross-case findings provided in this chapter represent my interpretation of the participants lived experiences of their shared phenomenon – the transition into the ACCP role. Through the application of the double hermeneutic (Smith et al., 2022), I have drawn together shared and convergent experiences, which highlight the similarities of their sense-making of their individual experiences, as well as ensuring divergent experiences are acknowledged. The following chapter will continue the interpretative process through the synthesis of the findings in relation to wider theoretical and published literature.

Chapter 9: Discussion

Introduction

This study provides an in-depth interpretative phenomenological analysis of the experience of eight critical care nurses who have undertaken a transition into an ACCP role. The participants shared a range of personal, professional and organisational level experiences which influenced their transition and impacted on how they have shaped their new role and identity within the wider team. As such the findings presented in Chapter 7 (Personal Experiential Themes – PETs) and Chapter 8 (Group Experiential Themes – GETs) are grounded in the systematic and iterative examination and interpretation of their experiences.

This discussion forms another layer of interpretation, as I analyse and synthesise the findings in relation to empirical and theoretical literature with consideration to concepts of interest - nursing, professional identity and role positionality. This was achieved through re-engagement with the literature presented to frame the study (Chapter 2 – Background) and literature exploring the existing body of research (Chapter 3 – Literature review), as well as consideration of additional evidence and theoretical concepts. This not only facilitates further contextualisation of the findings but aims to present a unique insight into the experiences of the nurses' transition into their ACCP role.

The chapter will begin with a reminder of the research question and objectives. The aim of this research study was to investigate the lived experiences of critical care nurses who have chosen to undertake a transition from their previous nursing role into that of an ACCP. The research question is:
What is the lived experience of critical care nurses who undertake the transition into an ACCP role?

Three objectives aligned to the research question were formulated:

1. To discover how critical care nurses perceive and navigate influencing factors during and following their experience of the transition into the ACCP role.
2. To explore how critical care nurses view their own professional identity and positionality within the healthcare team through their lived experiences of the transition into the ACCP role.
3. To formulate recommendations for future ACCPs, employers, workforce planners and education institutes to promote successful application of this role to meet the demands of critical care services.

The discussion of the findings that follows is framed in relation to the Group Experiential Themes. However, these are not necessarily sequential, and it is important to recognise that there are interconnections across and between the themes. As such the findings are not as linear as they are presented.

GET 1: "An explosion of a role" – navigating the transition

The first theme reflects the transition process, and the realities encountered by the participants as they attempted to understand their identity and positionality in their new role.

Each participant highlighted the diverse and at times complex nature of their experiences as they undertook their transition. Across the cases, similarities emerged regarding their decision for moving into an ACCP role. It was evident that they shared a common desire to progress their critical care career through being in a role which they perceived as the only option for remaining in clinical practice. Reflective of other studies (Kerr and Macaskill, 2020; Lawler et al., 2020; Ljungbeck et al., 2025; Lloyd-Rees, 2016; Maten-Speksnijder et al., 2015; Taylor et al., 2022; Timmins et al., 2023) there was a clear rejection of progression to other senior critical care nursing roles, echoing concerns regarding the limitation to senior clinical practice careers.

Findings in this study support the significance of intrinsic motivation, with some participants demonstrating active preparedness and planning for the role, sometimes taking years to reach their goal. Pink's Drive theory (2010) recognises that intrinsic drivers, or motivators, are often more powerful and productive than more traditional external motivators. For some of the participants, their self-drive reflected the motivational concept of 'purpose', which correlates to striving to gain a sense of satisfaction and value from undertaking a role (Pink, 2010). In contrast to having a long-standing ambition for the role, other participants appeared to take a more reactive approach to gaining their trainee role, exemplified by their accounts of responding to an unexpected opportunity. Whilst it was clear that Pink's (2010) Drive theory offers some insight into the power of different drivers and motivators, it does not fully explain why some nurses are drawn to advanced practice roles whilst many others are not.

A key factor to consider in relation to their transition and the experiences that followed seemed to be the challenges of navigating the significant changes in social structures and relationships. As well as the acquisition of new skills and knowledge which the participants expected, on commencing their transition, participants experienced significant changes to social structures and professional

relationships with others which contributed to a sense of uncertainty and conflict. Revisiting Bourdieu's (1990) key concepts provides a helpful theoretical lens to examine the shift in relationships within a given social space, or ***field***. Fields are constructed as a result of the complex relationships of those within it and comprises of its own rules and hierarchies. Existing power dynamics shape the positioning of individuals within the field, providing both opportunities and restrictions to practice (Piedrahita Sandoval et al., 2025). Bourdieu (1990) proposes that positions within the field are influenced by an individuals' ***habitus***, an accumulated set of values, experiences and dispositions which frame how the person may act and react in a certain way. The participants in this study previously occupied a distinct position as a nurse in the critical care field. Their practice as a nurse provided them with a professional habitus shaped by their inherent knowledge, skills and values. Consequently, their habitus had served them to understand the 'rules of the game' within the wider field that they had been positioned in for some time. Bourdieu and Wacquant (1992) refer to this as being a 'fish in water'.

Findings from this study found that on commencing the transition, the participants encountered a new social and professional field for which they did not immediately fit, leading to a sense of being 'a fish out of water' (Bourdieu and Wacquant, 1992). Previous studies acknowledge the importance of professional socialisation and the establishment of new professional relationships to support a successful transition into advanced level roles (Barton, 2007; Fleming and Carberry, 2011; Moran and Nairn, 2018). In contrast, participants found their transition experience to be challenging, characterised with high levels of stress and anxiety. Bourdieu (2000) recognised this disruption or mismatch between habitus and field, when the 'rules of the game' for the field are changed, resulting in a status he described as ***hysteresis*****.** Hysteresis signifies a period of instability, where the existing habitus and the field are altered sufficiently to cause a misalignment. Participants reported being unable to immediately recognise or establish themselves in their new field position despite formally being in the role. The result was a phase of uncertainty and a delay in recognising how their new role would function. My use of hysteresis contributes a new approach to understanding transition and professional identity formation in this study.

In this study, the changing roles and responsibilities and altered relational and emotional dynamics contributed to reality or 'transition shock' (Duchscher, 2009; Kramer, 1974). This further signified the impact of moving from a known position and identity as a nurse, to one which was less familiar or visible. Transition theorists such as Van Gennep (1960) and Bridges (2000) characterise the early stages of transition as a point of separation or removal from how things have been previously, which leaves the

individual trying to find their new 'normal'. The participant's transition was complicated by a lack of recognition or acceptance of the role, manifested through contrasting and contradictory positioning of themselves in the wider team. Participants held their own differing views regarding their role position, as to whether they were still nurses or if they had become something medical. For some, this conflicted with the opinions of other colleagues, who also appeared to have their own opinions where the role was positioned.

Dissonant perspectives on the positioning of advanced practice roles are not new. The ACCP role has been described as "providing an indigenous and permanent structure to the critical care medical workforce" (Denton et al., 2023: 146). Completion of predetermined competencies is a requisite for FICM membership (Faculty of Intensive Care Medicine, 2015). A similar role, the Emergency Care (EC) ACP, requires accreditation with the Royal College of Emergency Medicine (RCEM) (Ablard et al., 2025). The positioning of these roles as a subsidiary of medicine reinforces the argument of a replacement, or 'gap-filling' role, thus promoting the medicalisation of advanced practice whilst demoting the value of post-holders nursing practice (Lawler et al., 2020; Thompson and McNamara, 2022). Whilst some participants appeared happy to integrate their position as belonging within the medical hierarchy, alluding to an equivalence status with doctors, other participants felt more strongly in challenging this positioning.

Participants recognised the necessity to gain new knowledge and skills for their ACCP role, which privileged the acquisition of medical skills and social identity. However, the degree of role scope and agency was afforded by the permission of doctors. As such, participants found that their level of independence and autonomy was limited, as consultants and other stakeholders demonstrated power and control over the participants' new field of practice. In Bourdieusian terms, power within a social field is determined by the value of ***capital*** possessed by key agents in the field. Capital is generally represented in three fundamental guises; economic (monetary, assets), social (relationships, communities), and cultural (education, skills) (Bourdieu, 1986). Bourdieu (1989) later recognised symbolic capital which is concerned with prestige and status. In this study, social, cultural and symbolic capital was dominated by senior doctors and nurses which resulted in the displays of power and hierarchy experienced by the participants. The influence of power held by others on the transition into advanced practice roles is not a new finding in the literature (Andregård and Jangland, 2015; Kerr and Macaskill, 2020; MacLellan et al., 2016; Maxwell et al., 2013; Moyle, 2018; Thompson and McNamara, 2022; Wood et al., 2021; Woods, 1999). MacLellan et al.'s (2016) study of nurse practitioners highlighted significant issues relating to power, powerlessness and politics within the healthcare teams. They

reported accounts that senior staff deliberately withheld sharing key information with the practitioners, causing a culture of mistrust and hostility. Drawing on the work of Foucault (1980), power and knowledge are intertwined and a form of social control, signifying a relationship between professions and power. This helps to understand the dominance of medicine in maintaining control over its domain of practice and its medical knowledge, which as a form of scientific knowledge, holds significant prestige and status in healthcare (Lewis, 2022). In this study, participants experienced the application of power and occupational closure in different ways, such as the restriction or imposition of practice activities and competencies, or through placement on a particular type of medical rota with associated expectations and responsibilities. Having a contingent approach led to variation and discrepancy in the enactment and acceptance of their role, resulting in a reactive and problematic experience during the transition. Additionally, control of the scope of their role added to a sense of uncertainty and frustration, potentially curtailing their level of authority and autonomy.

The acquisition and displays of new capital (knowledge, specialist skills, additional qualifications) provided the ACCPs with a shared positioning alongside the doctors, enhancing their acceptance and status by that group. However, this study found that the opposite occurred with nursing colleagues. As the participants progressed in their transition to their ACCP role, there was a detrimental shifting of their position within the wider nursing team, which exacerbated their individual hysteresis. Social Identity Theory (SIT) provides a theoretical understanding of how professional groups are formed, which results in the assimilation of a distinct identity (Tajfel and Turner, 1985). Social identity derives from social or professional group membership where there is collective set of shared values, behaviours and knowledge, with members referred to as being 'in-group' (Bochatay et al., 2019). This is not dissimilar to the concept of professional habitus and the concept of 'fit' in a particular group or team. For an individual with an established identity and sense of belonging, a change in role or occupation positions them as now being different, thus categorising them as belonging to an 'out-group'(Caza et al., 2018). The transition to the ACCP role signified a perception that the participants were not seen as being nurses anymore, particularly by other nurses. Participants were made to feel different from nursing colleagues, even when they did not feel that way themselves, leading to a sense of marginalisation. This marginalisation was manifested in different behaviours such as undermining, ignoring, excluding the individual, leading to professional invisibility and even stigmatisation. Martin and Hutchinson (1999) originally identified this type of behaviour as 'discounting'. The concept was a particular focus in Anderson et al.'s (2020) study of ANPs in primary care settings, which uncovered covert examples of discounting behaviours by nurses who appeared to support the ANPs but in reality, were subtly trying to undermine their position.

The ACCP participants recalled clear examples of more explicit and overt negative behaviours and attitudes demonstrated by nursing colleagues. This included deliberate exclusion from nursing activities and direct challenges or dismissal of their new practice. Participants experienced an apparent disinterest in their role, or more seriously at times, a concerted and active resistance and opposition to the role. It is difficult to fully understand the reasons for the professional difficulties experienced by the new advanced practitioners. Studies have suggested that it could be a result of professional envy or jealousy displayed by nurse colleagues (Anderson et al., 2020; MacLellan et al., 2016; Wisur-Hokkanen et al., 2015), although it is acknowledged that it is difficult to evidence this due to the negative associations which make it more taboo to be discussed openly. The shared experiences reflect the concept of incivility, which consists of disruptive, rude or other negative behaviours displayed towards colleagues (Clark, 2019). Pinchera and Burnett (2025) recognise that incivility, with its pervasive and ambiguous activities, is challenging to recognise, particularly as it differs from other more aggressive forms of workplace bullying or harm. Unaddressed incivility prolongs the impact on the individual, potentially leading to stress, role burnout, and compromised patient care and safety (Ota et al., 2022). There is evidence that incivility and bullying occur within nursing (Jackson and Usher, 2025; Pinchera and Burnett, 2025), but these issues are less researched in relation to advanced practice roles. Clarke et al.'s (2024) study on interprofessional collaboration reported advanced practitioners' accounts of bullying and incivility because of the attitudes towards their role from a variety of nursing and other team members. The authors recognised the challenges in understanding the prevalence of this issue and suggest that emotional intelligence is a key mechanism to help address issues. The concept of emotional intelligence will be considered again in the next section, which considers how the participants sought to establish their identity and position as an ACCP.

GET 2: "There to care" – negotiating their identity and place

The challenges experienced during the transition process resulted in a range of emotional responses reported by the participants, including feelings of frustration, changes to confidence in their professional abilities, and for some, significant levels of stress and anxiety. It was evident that there was a prevalence of loneliness experienced by many participants as they were disconnecting from their previous nursing role and team. Other studies have recognised that nurses can experience a sense of feeling alone or uncertain of their position as they move through a transition (Andregård and Jangland, 2015; Jangland et al., 2016; Ljungbeck et al., 2025; Wisur-Hokkanen et al., 2015; Wood et al., 2021). In this study, the impact of isolation and loneliness was exacerbated by the previously discussed negative behaviours and exclusion initiated by nursing colleagues. This period of destabilisation continued to exacerbate the state

of hysteresis, disrupting the established sense of belonging bestowed by their nursing identity. The principle of belonging, or 'belongingness', grants the individual alignment to a particular group, such as nursing (Levett-Jones et al., 2007). As a concept, belongingness is aligned to both sociological and psychological theories. Reflective of Social Identity Theory (Tajfel and Turner, 1985), belonging suggests that the individual is 'fitting in' with the group, which in turn positively impacts on job satisfaction and contributes to an improved self-esteem (Patel et al., 2024; Rasmussen et al., 2018). Similarly, Bourdieu's (1990) concept of habitus had previously provided the participants with a structured and ordered position within the field of nursing, for which the existing social and cultural capital holds value, thus supporting belonging.

The impact of being removed from the customs and routines core to their nursing practice was something the ACCPs were not prepared for. The disruption occurred whilst they still had not fully established a sense of belonging within their new role and field of practice. Bridges (2003) describes this period of time in a transition as being between 'was' and 'will be'. This phase relates to the concept of liminality, derived from the Latin word *limen*, which means 'threshold', and is attributed to the original 'rites of passage' work by Van Gennep (1960). Van Gennep's (1960) model of social transitions, utilised to frame Barton's study of the transition of student nurse practitioners (2007), posited transition as occurring in three stages - *Separation, Transition, and Incorporation*. The Transition stage is a liminal stage when being in-between the past status and the future status occur. Turner (1969) had also explored Van Gennep's (1960) work on this subject, and described liminality as being '"neither here nor there; they are betwixt and between" (1969: 95). Drawing on these seminal concepts, it was clear that being in a state of liminality placed the participants in a state of limbo or in-betweenness, which resulted in a physical and psychological gap in their individual identity and positionality.

Participants who had other trainees or ACCPs in the team benefitted from enhanced support and guidance during the transition. The value of role modelling is reported in previous studies (Kerr and Macaskill, 2020; Mannix and Jones, 2020; Maten-Speksnijder et al., 2015). Wenger's (1998) Community of Practice (CoP) concept posits the necessity of positive relationships with others who share key traits and characteristics, key to supporting professional learning. The CoP framework considers learning to be a social collaboration situated within a community where members may undergo transition and identity formation. Kerr and Macaskill (2020) describe this period as 'learning the craft' of the role, which goes beyond the achievement of clinical skills or qualifications. Professional socialisation and effective role modelling therefore supports the transition process into a new role, and the establishment of an individual's identity and habitus. However, not all participants in this study had other ACCPs or trainees

in their teams, thus lacked role models or others who understood what they were experiencing during the transition. This exacerbated the sense of feeling isolated, leading to individuals feeling anxious and overloaded in relation to their work and role expectations, contributing further to the hysteresis during the transition.

It was clear that participants appreciated that they were undertaking an advanced practice role associated more closely to the paradigm of medicine. A distinct finding in this study was that each of the participants recognised that they were applying nursing skills, knowledge and identity within their ACCP role. As well as explicit declarations of their pride for their nurse identity, there was strong evidence of their own unique 'nursingness' remaining a core part of their new role in practice. Examples of patient-centredness, valuing the need for holistic care, and displays of empathy, amongst other things, supported their enactment of nursing practice within their ACCP role. Li et al. (2023) argue that nurses moving into advanced practice roles are not a 'blank slate' but instead their new role is built on the foundations of their experience and knowledge from their previous nursing role. However, much of the UK literature pertaining to professional identity and advanced practice roles focuses on roles which have 'nursing' in the title, for example (Anderson et al., 2020; Fleming and Carberry, 2011; Kerr and Macaskill, 2020; Thompson and McNamara, 2021; Wood et al., 2021). This promotes nursing as a core part of the role and identity, whereas the value of the practitioner's heritage is less specified in more 'omni-professional' roles, such as the ACCP role. The literature suggests that more medicalised advanced practice roles dismisses, devalues or fails to acknowledge the professional heritage of the post holder (Ablard et al., 2025; Denton et al., 2023; Lawler et al., 2020; Timmins et al., 2023). Ablard et al.'s (2025) recent study of emergency department ACPs found some participants had undertaken elements of their previous role, particularly to help colleagues. However, they also reported that medical staff did not appreciate this happening, although it is not explained why. One conclusion could be that non-medical activities were not valued, suggesting that only medical 'capital' (skills and knowledge) is respected and appreciated in the new field.

What was apparent in this study is that the participants' identity as an ACCP was influenced by both disciplines of nursing and medicine. Barnes (2015) describes the straddling of two identities during a transition into an advanced practice role as a period of not identifying as what they were nor what they are working towards. This is significant as it exacerbates the state of liminality and hysteresis. This study found that some discomfort and dissonance was experienced from being in-between two different and at times conflicting cultures with the differing attitudes and beliefs. This resonates with earlier research. Aagaard et al. (2017) suggests that transitioning into an advanced practice role causes tension between

the ‘technical’ and skills focus of the new advanced role, with the nursing and patient centred care aspects of their nursing role. The challenge therefore appears to be finding a way to synthesise the old and new paradigms of practice (De Rosis et al., 2023).

For participants in this study, being viewed as different from both nurses and doctors appeared to reinforce resistance and other forms of disruption to their practice, further contributing to challenges they experienced during the transition process. Originating from work on culture and scholarship (Bhabha, 1994), ‘third space’ is described as an in-between space (or position) between two social cultures or groups. Chulach and Gagnon (2016) drew on this concept to argue that nurses in advanced practice roles often occupy the position in between two or more cultural systems such as nursing and medicine, creating a form of ‘cultural hybridity’ which draws elements from both paradigms. Occupying this space can potentially create uncertainty and disruption to established boundaries of practice. However, being in a position situated in-between the two professional groups offered the participants the chance to re-establish themselves in a new way, in supporting the wider team, utilising facilitation and conciliation skills. For the participants, it was important that they were recognised by other nurses as being a nurse still, thus reinforcing their nursing professional identity. Examples were clear as to how they did this in the practice setting, drawing on their existing nursing knowledge and skills even during the enactment of medical procedures or activities. Consequently, the merging of their existing nursing heritage and habitus with the newer capital gained through the development as an ACCP role enabled the formation of a new, richer habitus.

The participants expression of retaining their nursing identity contrasted with the social and professional disconnection from the wider nursing community that they experienced. It also challenges the assertion of transition theories which describe the process as being a move from one role and identity to a new on. Bridges (2003) distinguishes transition as being the psychological process of reorientating and redefining that needs to occur as a result of a change, such as undertaking a new role. Commencing with a stage of ‘Endings’, individuals recognise that they will need to relinquish what they were to change to their new role and identity. Similarly, Van Gennep’s (1960) first stage Separation, also termed as pre-liminal, occurs when the individual detaches from their previous social position and relationships and may incur a sense of moving away from their previous professional identity. In this study, participants did not fully relinquish or end what they were (nurses) and appeared troubled by the enforced level of detachment from their previous social position.

It was apparent in this study that the participants felt a sense of pressure to succeed and be accepted as an ACCP. For some this was heightened as they had undertaken the transition in their original ITU, which appeared to add another layer of expectation to succeed. All the participants reported a myriad of emotions such as stress, anxiety, feeling like an imposter in the role, or having a reduction in their confidence. This is not a new finding, and is reflected in the wider advanced practice literature (Barnes, 2015; Brown and Olshansky, 1997; Fleming and Carberry, 2011; Jangland et al., 2016; Kuczawski et al., 2024; Li et al., 2023; MacLellan et al., 2015; Mannix and Jones, 2020; Moran and Nairn, 2018; Owens, 2018; Piil et al., 2012; Pleshkan and Hussey, 2020; Wisur-Hokkanen et al., 2015).

The participants' experiences demonstrated a shift in status from trying to survive the initial transition period as a trainee ACCP, to one of thriving in the role. Participants employed a degree of emotional intelligence, demonstrated through self-awareness of their own emotions and needs, whilst being empathetic to others. Emotional intelligence is not explicitly featured in the studies in the scoping review. However, the key components associated with it – such as being able to assess and manage your own emotions, as well as recognise and respond to others' emotions, and to enhance personal and professional relationships (Goleman, 1996; Kidner, 2022) – are recognised as core attributes of an advanced practitioner (Anderson, 2018; Clarke et al., 2024). There was a clear shift in their own mindset as they moved from providing care as a nurse to being the decision-maker and prescriber of care delivered by others. Barnes' (2015) acknowledges this shift as a time of increased autonomy and responsibility, something that was acutely recognised by some participants as they established their ACCP role. Despite the acute hysteresis state, they found themselves in, participants demonstrated fortitude and resilience as they endeavoured to fully embed their role in the wider team and ensure it was a successful transition.

GET 3: "I think it will get better, won't it?" - vulnerability, concern and hope

As qualified ACCPs, a range of personal, interpersonal and organisational factors had contributed to their thoughts and experiences regarding how they saw the ACCP role now and in the future. The study revealed significant tensions between the ACCPs and senior nurses particularly nurses in leadership positions such as nurse managers or Matrons, which further compounded the deterioration in nursing relationships discussed earlier. Having effective workforce planning, leadership and governance for advanced level practice roles at both a service and strategic level is considered essential in ensuring organisational readiness (Faculty of Intensive Care Medicine, 2023; NHS England, 2024). The influence of nursing leadership on advanced nurse practitioner roles is important in ensuring a positive workplace

culture, which in turn promotes effective integration of the nurse into the advanced practice role and into the wider healthcare team (Kerr and Macaskill, 2020; Ljungbeck et al., 2025; MacLellan et al., 2016; Maxwell et al., 2013; Wisur-Hokkanen et al., 2015), although these studies focus on advanced nursing roles which remain within the nursing team hierarchy.

Participants appeared to readily accept the lack of direct professional nursing leadership for their ACCP role. Reflecting the hybrid nature of the role, it is recommended that line management of ACCPs is shared between medicine and a senior member of the base profession of the individual, in this case nursing (Intensive Care Society, 2022). This study found that where there was senior nurse involvement in the ACCP management structure, participants generally viewed this as not being a positive experience, due to a perceived lack of interest or lack of understanding of the role. This appears to be contradictory with the positioning of the ACCP role in the Adult Critical Care Nursing Career Pathway (UK Critical Care Nursing Alliance, 2024) (See Figure 1). Similar to the ACCP role, the Advanced Nurse Practice in Critical Care (ANPCC) role in Northern Ireland is aligned to the FICM ACCP standards (Devlin et al., 2023). The key difference is that this role is clearly positioned as a nursing role, and as such acknowledges the essential requirements of maintaining the NMC Code (Nursing and Midwifery Council, 2018c) and associated values of nursing. The NMC has recently published *Principles for advanced practice* in readiness for more formal regulation of advanced level practice, with the development of standards of proficiency, and advanced practice programme standards due in 2027-8 (Nursing and Midwifery Council, 2025). The purpose of this work is to promote greater clarity and consistency to advanced level practice undertaken by registered nurses (and midwives), ultimately to ensure safety of the public. Nurses in ACCP roles currently require continuing professional registration with the NMC, something that the participants were comfortable with. However, achievement and maintenance of the FICM standards, which are aligned to the broader Multiprofessional Framework (Health Education England, 2017; NHS England, 2025b) have been the prominent standard to be evidenced. In the future, nurses who are qualified ACCPs will be required to demonstrate mapping of their role to the NMC advanced practice framework. It remains to be seen whether this new regulatory framework will shift the balance of perception and leadership for ACCPs, to facilitate a more effective tripartite approach between medicine and nursing.

It is difficult to explain with certainty why the disconnect between senior nurses and nurses in ACCP roles happened. Returning to earlier concepts such as power dynamics (Foucault, 1980) is helpful. The growth of the ACCP role has positioned nurses in higher role bands than they held previously, putting them on a par or even on a higher band than other senior nurses, some of whom they have worked with

for some time. Additionally, the acquisition of new knowledge, skills and practice agency means the ACCP possesses more, or certainly different, specialist capital which the senior nurses do not have. An exacerbating factor for some participants related to their experience during the COVID-19 pandemic, which saw some of them redeployed back into nursing roles, seemingly without the agreement of the medical team whom they believed oversaw their ACCP role. This resulted in the lack of trust or confidence in the senior nurse(s), further intensifying a culture of divisiveness, lack of professional respect and, for some participants, overt incivility. The deterioration of professional relationships presents risks to effective inter-professional collaborative practice, and the delivery of safe, high quality care (Xyrichis and Rose, 2024), particularly if communication and information is not shared, as discussed earlier. It is important therefore to understand how senior nurses perceive the ACCP role, and how nursing leadership for ACCPs is viewed and enacted by senior nurses. This would be an area for future research.

The absence of nursing input and leadership at local (ITU) level potentially exacerbated the poor role visibility and understanding at an organisational (i.e. Trust) level that some participants spoke about. In this study, representation at forums or other organisational and strategic groups, either directly or through an advanced practice lead, was positively valued as providing participants the opportunity to 'have a voice' regarding advanced level practice matters. However, a consistent finding was the frustration felt by the participants that their role and jurisdiction to practice appeared to not be recognised or understood outside of the critical care unit, an ongoing issue for advanced practitioners despite the increasing prevalence of similar roles (Clarke et al., 2024; Kerr and Macaskill, 2020; Lloyd-Rees, 2016).

Participants demonstrated a high level of protective behaviours and attitudes regarding their ACCP role. The FICM (Faculty of Intensive Care Medicine, 2015) ACCP curriculum requires completion of competencies, reflecting a distinct and measurable level of biomedical knowledge and technical medical skills required for the role. Completion of these, and accreditation with FICM provided the participants with new capital, which enhanced their changing habitus and, in turn, their position in the field. As discussed earlier, this contributed to a greater sense of belonging and positioning with the medical team, although it also set them apart from nursing colleagues to some extent. Embedding their ACCP role and identity appeared to create a separation from other advanced practitioners, as the participants positioned and elevated the ACCP educational and practice-based standards above that required for other advanced practice roles. The adoption of a protectionist attitude reflected a form of social or occupational closure, in a similar way to that exhibited by some medical colleagues to the trainee ACCPs

during their transition. It also reflects the concept of 'othering' and 'otherness' which positions one group as sub-ordinate to another more dominant group (Bhabha, 1994). Developing this concept, Anderson et al. (2020) found lateral othering, the self-positioning of one group of advanced nurse practitioners over others, was employed in an attempt to distinguish the role as being more outstanding. This was indicated in this study, as findings suggest that the participants sought to establish greater validity and value for their own roles both within their own field, for example when considering the quality of other ACCPs, as well as in the wider organisation field in relation to other advanced practitioner roles. This positioning could be viewed as concerning as it impacts on the development of cohesive collective or group identity and dilutes the influence and impact of advanced practice roles, particularly in NHS organisations that employ both ACCPs and other advanced practitioners (such as ACPs). Having a better understanding and recognition of advanced practice roles across the organisation has been shown to promote role longevity and retention (Kuczawski et al., 2024), ensuring ongoing stability to the workforce and service provision.

Participants recognised that the implementation of the role in their organisation was in response to medical workforce problems, which was viewed pragmatically as a positive opportunity. The trainee period and transition into a qualified ACCP role offered a high level of education and development opportunities. However, once established in the role, there appeared to be limited options for promotion, and limitations for further role development as an ACCP. A prolific period of advanced level practice role growth, particularly following the implementation of the HEE (2017) Multi-professional framework, has created an emergent issue regarding the lack of a career structure or progression for advanced practice roles (Kuczawski et al., 2024). Sustainability and growth of advanced practice roles relies on organisational resourcing and the patronage of key players, including powerful professional groups such as medicine and NHS workforce planners/managers (Drennan et al., 2022). For ACCPs, potential career progression options include gaining a senior or lead role for an ACCP team, or a non-medical Consultant role. However, Timmins et al. (2023) suggest that options for promotion for advanced practitioners may be limited to a move into a management role, ironically something the participants had not wanted to do prior to their transition. Participants were frustrated but resigned to imposed constraints on their career development. They were however concerned about the lack of career opportunities for future ACCPs. Participants drew on their own experiences to illustrate strategies for being successful in attracting and retaining trainees, including diversification within the role. It is well documented in the literature that factors, such as mentorship, role clarity, job satisfaction, and positive inter-professional relationships, enhance transition and are key to promoting retention of experienced advanced practitioners (Anderson et al., 2020; Kerr and Macaskill, 2020; Kuczawski et al.,

2024; MacLellan et al., 2016; Wood et al., 2021). These factors were not consistently evidenced in the experiences shared by the participants, with some actively raising questions they had about the future of the role.

The final part of the discussion reflects the immediate and ongoing impact of the COVID-19 pandemic which formed part of the lived experiences of the participants. The impact of the pandemic on critical care provision is well-documented (Thomson et al., 2023; Tyrrell et al., 2021). The increase in numbers and types of critically ill patients requiring admission and treatment meant many NHS Trusts were required to expand their capacity through the use of alternative human and physical resources from elsewhere in the organisation. This included using operating theatres or other clinical areas for admitting and caring for sick patients and redeploying non-critical care staff to work within the speciality (Endacott et al., 2022). This led to the rapid emergence of new models of staffing which were based on task or team approaches, as opposed to the more holistic approach of 1:1 care which is the standard for Level 3 critically ill patients (Credland and Gerber, 2021). In reality, this meant care was organised in the form of 'pods' of non-critical care nurses (or other healthcare professionals) delivering care for a group of patients under the supervision of a critical care nurse (Carter and Notter, 2020).

All the participants were in their trainee or qualified ACCP roles when the impact of the pandemic began to manifest. Some participants remained in their ACCP role, whilst others were redeployed back into the wider nursing team, with differing opinions as to how this was experienced. Whilst all participants remained in the ITU workforce, they appeared to demonstrate a degree of modesty and understatement when reflecting on their own role during the time. The rapid onset and unpredictability of the situation resulted in changes to how critical care was staffed, which resulted in significant changes to the levels of responsibility afforded to nurses and other professionals who were drafted into intensive care from other settings (Endacott et al., 2022).

Participants spoke sensitively and empathetically about the challenges faced by colleagues, recognising many were working in a way that did not reflect their usual practice. Many of the elements which distinguish critical care nurses, such as delivering humanised, evidence based, and high quality care, became increasingly difficult to provide (Credland and Gerber, 2021). Studies have evidenced the significant impact on critical care nurses from working in extraordinary conditions, acknowledging that nurses experienced a high level of moral distress caused by missed or sub-optimal care (Miller et al., 2024; Montgomery et al., 2021; Stayt et al., 2022). These studies did not consider advanced practitioners explicitly, however Rogers et al.'s (2022; 2024) study focussed specifically on the emotional

and spiritual well-being and resilience of advanced clinical practitioners working in a range of settings during the pandemic. Collecting data in two phases, the study found that the respondents continued to have lower levels of resilience and well-being at the second data evaluation point, particularly those from acute areas such as critical care. The authors suggested potential contributing factors such as availability of support from others including professional leadership, and challenges relating to their self-identity within their wider community of practice. The emergence of initiatives such as restorative clinical supervision used in the Professional Nurse Advocate (PNA) role (NHS England, 2025c) aim to support nurses to enhance their mental health, resilience and well-being. The use of this in critical care is seen as beneficial in reducing stress and burnout, particularly when supported with visible nursing leadership (Credland et al., 2024), although the extent that this is utilised by nurses in ACCP roles is not known.

Chapter summary

This chapter has situated the findings from this research in the context of the wider theory and literature relating to the concepts of interest - transition, professional identity and role positioning. The development of the GETs and the subsequent discussion reflects a continuance of the interpretation of the nurses' lived experiences as they underwent a transition into the ACCP role.

Drawing on Bourdieu's concepts (1990) this study has found that the transition into an ACCP role is an interplay between how the existing habitus of the nurse transfers into the new field of play, and how the established key players are affected by the change. The concept of hysteresis has provided a framework for understanding the change to the individual participants own habitus, identity and sense of positionality within the field as they underwent the transition. A complexity of personal, situational and professional factors influenced the transition. In particular, the inter- and intra-relational changes and at times hostile encounters with other members of the nursing and medical teams directly impacted on the participants. For participants in this study there was a clear sense of betrayal and abandonment resulting from the sense of being rejected by their nursing colleagues, which further impacted on the state of hysteresis during the transition. The findings draw attention to the emotional and professional disruption that the nurses experienced when moving into an advanced role, which left them needing to make sense of their changing role and position.

The state of hysteresis continued to be exacerbated as a result of the shifting of the participants position within the field (the social and cultural spaces), affecting how they re-established a clear sense of their own professional identity. The ACCP role is aligned to the rules of the dominant players in the field,

specifically medicine. The transition process facilitated the participants to accumulate new commodity or capital, which was predominantly constructed from the medically focussed qualification and skills, and adoption of the social, cultural and language expectations of the group. This promoted the establishment of a more stable position within the medical field. Contrary to the literature regarding medicalised or controlled advanced practice roles, this study clearly demonstrated the high value held by participants to retain and enact their nursing identity and practice. Participants actively utilised their nursing habitus actively to re-form constructive relationships with nursing colleagues, through the creation of opportunities which would help to establish a sense of belonginess for them. This required the participants to find strategies to adapt to the challenges encountered to find their own position and identity as an ACCP.

There was continuing tensions for ACCPs even when their trainee period and transition into the role had been completed. Positioning of the role within the wider organisation presented challenges for the ACCPs, particularly when there was continuing friction between them and senior nurses. This was conveyed further by the apparent lack of nursing leadership or formal input in their professional management in the ACCP role. This study draws attention to the need to reconsider how nurse leaders recognise and inter-relate to the nurses in these roles, particularly given the heightened expectations of the NMC when the new advanced practice regulatory standards are enacted (Nursing and Midwifery Council, 2024a). Despite a clear attempt to promote the value and importance of the role, the study found that the participants also sought to differentiate their role from more established, and possibly more recognised advanced practice roles in the organisation. Finally, this study pays attention to the experiences raised by the participants from working in critical care during the COVID-19 pandemic. Whilst it would never claim to be an extensive exploration of this part of the participants experience, it is hoped that it is respectful of a time of vulnerability, concern and hope.

Chapter 10: Conclusions, recommendations and reflections

Introduction

The preceding chapters have presented in detail the rationale, methodology, design, and findings from this IPA study which aimed to answer the research question:

What is the lived experience of critical care nurses who undertake the transition into an ACCP role?

Three overarching themes have emerged which answer the research question. GET 1: *"An explosion of a role" – navigating the transition* provides insight into how the nurses decided to start a transition into the ACCP role, and the realities of their experience. GET 2: *"There to care" – negotiating their identity and place* considers the strategies for managing the challenges of their transition, particularly the sense-making of their own professional identity. Finally, GET 3: *"I think it will get better, won't it?" – vulnerability, concern and hope* captures how the ACCPs are experiencing their future as an ACCP, and factors which could impede the role for others who want to do it in the future.

This chapter presents a summary of the research and its key findings. Attention will be drawn to the novel and unique features from this study, allowing recommendations and suggestions for future research to be made. The chapter will also provide evaluation of the quality of the study that has been conducted, highlighting strengths and limitations. Finally, I will present a last reflection on my experience as a researcher.

Summary of key findings

The origins of the ACCP role can be traced to 2008 and so is not a new role in UK healthcare. However, as a role that is particular to one clinical speciality – critical care – and due to the relatively low numbers of post-holders (in comparison to other advanced practice roles), it has gained little attention from researchers, or in policy. This may be due in part to the historical focus on ANP roles, and the more recent focus and dominance of Advanced Clinical Practitioner roles, following the publication of the MPF (Health Education England, 2017).

This research has shown that the transition into an ACCP role was a significant experience for the nurses. Transition for them was not just a process or set of stages to move through, as suggested by some transition theories (Bridges and Mitchell, 2000; Meleis, 2010; Van Gennep, 1960). Instead, it was experienced as an unpredictable, challenging, dynamic process, affected by a myriad of individual, interpersonal and organisational variables. Findings from this study demonstrated that the motivation for undertaking a transition into the ACCP role was not a rejection of the desire to be a nurse anymore.

In fact, participants appeared to be completely unprepared for the impactful removal and rejection of their nursing status and identity by others. This was compounded by a contingent approach to the preparation, recognition and support offered to them as they moved into their new role, resulting in significant emotional and psychological challenges. This finding is underpinned by the concept of hysteresis (Bourdieu, 2000), a disruption and dislocation of someone's social positioning and identity.

The complexity of working in an advanced practice role which sits closer to the paradigm of medicine was evident from the participants narratives. However, by drawing on professional nursing practice, experience and knowledge, the participants demonstrated the ability to reflect and adapt to ensure their nursing identity was recognised and valued, particularly by other nurses. There was a clear intent to retain their nursing values within the ACCP role, thus promoting a holistic and patient-focussed approach to their practice. The tension between preserving a nursing professional identity whilst practising in a medicalised role resulted in locating them in a third-space, or hybrid position between the paradigms of medicine and nursing. However, this was not reflected in the formal professional support or relationships with senior nurses. The experience of the transition, the challenges of establishing a clear professional identity and the variance in positionality within the wider team influenced the participants when considering their future. In addition, there is clear concern for ACCP career opportunities, for themselves as current ACCPs but also for future practitioners. Furthermore, organisation factors at local (ITU), strategic and national levels, such as governance and maintenance of professional standards for the role, contributed to a sense of uncertainty regarding the sustainability and longevity of the ACCP role.

Original contributions

This is the first study that explores the lived experience of critical care nurses who transition into an ACCP role. Furthermore, the study makes an original contribution to address an area which lacks empirical research, specifically how nurses navigate their professional identity and positionality within a medical paradigm of practice in critical care. This has provided unique insight into the participants lifeworld regarding their transitional experiences and (re)construction of their professional identity in their new ACCP role.

This study takes a novel approach to studying the transition into advanced practice roles through the lens of Bourdieu's (1990) conceptual tools of habitus, field and capital. Specifically, to the best of my knowledge, this is the first study to draw on the concept of hysteresis (Bourdieu, 2000) in the exploration of transition from one role to another. Hysteresis offers a unique perspective in understanding how the

participants underwent a form of 'shattering' of their original habitus and professional identity as they commenced their transition. This study demonstrated that transition comprised of a set of significant social, cultural, professional and psychological considerations that in this study were not understood or expected by the participants. Understanding the complexities of transition as not being just a process or set of stages, typified by the acquisition of a qualification or job role, is vitally important.

Findings have shown that the growth of the ACCP role has not been matched with a clear career structure for more experienced ACCPs following their transition and consolidation of the role. There were concerns and frustrations that they could remain in a form of status quo for many years. Some participants had taken the opportunity to create a niche for their own role that enabled a sense of ownership and leadership on that element of their scope of practice. The findings have also revealed that participants demonstrated a significant protectionist approach to the role, which found them positioning themselves as different and potentially better than other ACCPs.

The use of IPA has introduced a new methodological approach to studying the experience of nurses who move into an ACCP role and so contributes to creating new evidence which will be of value to future research. IPA has not been used before to explicitly explore the experience of transition into an ACCP role, or any other advanced practice roles. Utilising IPA as a methodology as well as a structured method resulted in the production of distinct themes at the individual and group level. Therefore, the use of IPA has ensured experiences which are distinctly idiosyncratic to the individuals and are embedded in their own lifeworld experience have been privileged, whilst attending to the formation of higher-level conceptions of the social and professional experiences of transition.

The study facilitates an understanding of the influences on how transition into advanced practice roles, particularly the ACCP role, is experienced. The findings provide insight regarding how professional identity and positioning occurs within the wider field of practice. As such, this knowledge may help to inform future ACCPs, as well as workforce and educational practices at different levels. The following section will present the main recommendations and suggestions for further research.

Recommendations

For individuals

It is recommended that nurses transitioning into ACCP roles actively engage in activities which promote mechanisms for managing challenging and diverse behaviours. Opportunities to further develop and enhance 'softer skills' such as resilience, self-awareness, reflection and emotional intelligence should be

viewed as valuable as gaining technical skills such as advanced airway management. This study, and other research, has shown that individuals with these techniques fare more positively in establishing their positioning in a team, and endure fewer impactful stressors when embedding their new role and identity.

All nurses in ACCP roles must be aware of the imminent NMC standards for advanced level practice (Nursing and Midwifery Council, 2024a). Whilst the participants in this study positively affirmed their commitment to remaining a nurse, it is possible that other nurse ACCPs may not feel the same way. All registrants will be required to meet and adhere to these irrespective of their job title. It is therefore recommended that nurses in ACCP roles engage in negotiation and collaboration with senior nurses and medical leads to ensure they can demonstrate the expected knowledge, skills and behaviours of the standard which places patient care and well-being at the core of their nursing values.

The ACCPs in this study demonstrated patient centred care within a role which could be viewed as fully medicalised, rooted in a culture of cure. Adopting a 'third-space' or hybrid position enabled the heritage professional identity (their habitus) to meld with the newer acquisition of ACCP skills and knowledge. Nurses in ACCP roles need to be able to promote and explain what the role is about and how it can complement and merge the paradigms of nursing and medicine. This positioning will promote improved patient outcomes and experiences, ensuring safe person-centred care.

For practice – local and organisational settings

It is recommended that greater and more visible collaboration between senior nurses and nurses in ACCP roles be urgently established. The governance and leadership of ACCPs is recommended to be shared between nursing and medicine (Intensive Care Society, 2022), but in this study, this was mainly not achieved or even desired by some participants. NHS managers, medical consultants and nurse leaders should consider how to instate and maintain positive tripartite leadership of ACCPs in a way that is effective and meaningful for all involved. Having senior nurses actively partaking in the leadership and professional oversight of nurses in ACCP roles will promote a greater understanding of the role, as well as be beneficial in responding to professional issues or queries. This will help to embed a more accepting culture for the role, enhancing intra-professional relationships and respect.

There is a need to support the future ACCPs about the reality that the transition will bring, that it is not just a qualification to be gained but also it will require a shift in their identity, positionality and possibly some professional relationships. This study has shown the importance for ACCPs to have appropriate

role models who have strong insight into their professional position and identity. This may be increasingly viable as ACCP numbers grow, but this study found that many ACCPs were isolated or had limited access to others in the same or similar role. The support from peers, whether that is immediately within the ACCP team, or with other advanced practitioners in the organisation will provide valuable support. For the nurse undergoing a transition, it is recommended that they are provided with the support and guidance of others who have had a similar experience. This will help to reduce imposter syndrome and help with other issues or tensions as they establish themselves in their new field of practice.

There needs to be a robust organisational approach to support the understanding and agency of ACCPs outside of critical care. The role offers a unique model of advanced practice that embraces not only the medical approaches to the role but also includes the essence of nursing paradigms of practice. Improving the engagement with and for the ACCPs in the organisation will help reduce ambiguity of the role, as well as address and reduce inter-professional conflict and boundary protection. Recognition of advanced practice roles should be supported with proactive review of organisational policies, guidelines and other operational procedures. Additionally, future workforce policies need to consider the impact on professional identity and inter-professional team working.

The role should be seen as an important addition to the wider multi-professional workforce in the organisation, recognising the distinctive value it adds to the delivery of effective, quality patient care. Where possible, strategic and operational leadership roles for ACCPs will be beneficial in promoting the role visibility as well as reducing the reliance on medical patronage, with its associated power dynamics.

For professional bodies and regulators

There is scope for professional bodies and other groups such as FICM and NHS England to recognise the diversity of advanced practice nursing roles, and ensure guidance and support enables the nurses to maintain a clear professional identity. Regulation of nurses in advanced practice roles will provide clearer assurance and awareness of the role to the profession, to employers and to the public. There are already several frameworks and standards including the FICM ACCP curriculum (Faculty of Intensive Care Medicine, 2023)and the NHS England ‘Multiprofessional framework for advanced practice in England’ (NHS England, 2025b). It is essential that there is alignment across these and with the pending NMC standards to facilitate recognition of the range of advanced practice roles being enacted, including the ACCP role.

For educators

It is recommended that Higher Education Institutions involved in the delivery of master's courses which prepare ACCPs provide strategies to support and address issues of transition, professional identity, and professional relationships. Trainees would benefit from the provision of theoretical constructs for these topics, as well as real-world examples of how they may manifest. Additionally, providing strategies and content which develop and enhance resilience, self-awareness, reflection and emotional intelligence as part of the course will better equip practitioners for their transition. Understanding and acknowledging the potential for transitional shock or hysteresis allows the individual to recognise when issues start to arise, and to develop coping strategies to mitigate the impact.

Students on advanced practice courses, including those on ACCP programmes are multi-professional, and it is usual that the educators are multi-professional too. Educators should have strategies within the curricula which encourages safe debate and challenge to established stereotypes of roles, professional hierarchies and interprofessional conflict. Exploration of theories relating to professions and boundary work will encourage recognition of why conflict and disruptive behaviours manifest in the wider team.

Future research

Participants were all qualified ACCPs who have completed their own transition. Many of them were the first to undertake the role in their organisation. An area for future exploration could be through seeking the experiences of trainees who are beginning their own transition into the role. This would be important to explore if the professional, social and cultural factors evident in this study remain as factors of concern for new ACCPs transition.

It is recommended that research is needed which aims to explore the views and perspectives of senior nurse leaders regarding the ACCP role. This would help to understand how they position the role, and how they perceive its value to the wider nursing team. Findings could then inform both nursing strategies as well as organisational approaches for promoting inclusivity and integration of nurses for nurses in ACCP roles. This would be beneficial in ensuring the ACCPs had the opportunity to contribute more to the wider development and leadership of nursing teams, which would have a positive impact on how other nurses are enabled to deliver safe and holistic patient care.

This study deliberately focussed on nursing advanced practice, and the findings are particular to the profession of nursing. It is hoped that the findings could inform how other professional groups who undertake advanced practice roles, including the ACCP role, experience the tensions from role

transition. This study provides a platform for future research which could focus on the nuances of other professional groups' own distinct professional identities and positioning in the wider team. In particular, this study has shown the applicability of utilising Bourdieu's (1972; 1984) thinking tools concepts to frame future investigations concerning the positioning of roles within a wider social fields.

Exploration of the views of other critical care nurses, senior nurses and critical care doctors would clarify how they view the identity and role positioning of ACCPs. By understanding how others react and behave towards the ACCPs, strategies for addressing potential threats to professional identity and belongingness can be formulated. The impact of this would be to create a more cohesive and collaborative multi-professional team who all shared a common purpose of providing evidence-based, effective and safe patient care.

These recommendations have arisen from the findings generated through the lived experiences of eight participants, so could be argued as requiring a more tentative consideration. It is important to remind the reader that some of the findings extend empirical knowledge and theory reported previously, whilst some findings are unique because of this research. To support my claims for its impact, the following sections consider how research quality and integrity were upheld.

Evaluation and reflections

In line with IPA guidance (Smith, 2011a; Smith et al., 2022; Smith and Nizza, 2022) and consideration of Levitt et al.'s (2018) criteria for reporting qualitative research and Yardley's (2000) four broad principles for assessing qualitative research, attention to quality has been practised throughout the development and conduct of this study. The application of Yardley's (2000) principles is summarised in Chapter 5.

It is suggested that IPA researchers inform their study through a relatively simple literature review to create an argument that the research is needed (Smith et al., 2022). As part of the doctoral process, I went further by undertaking a scoping review, with the rationale for this outlined in Chapter 3. The scoping literature review was conducted in a systematic way, following Arksey and O'Malley's (2005) staged framework, whilst reflecting current scoping review best practice guidelines (Tricco et al., 2018).

Smith (2011a) outlined the first criteria to specifically judge IPA studies as being 'Good', 'Acceptable' or 'Unacceptable'. Building on this work Nizza et al. (2021) outline four quality indicators representative of 'Good' quality IPA research:

- Constructing a compelling, unfolding narrative
- Developing a vigorous experiential and/or existential account
- Close analytic reading of participants' words
- Attending to convergence and divergence

The following discussion attends to these individually, but it is recommended that they should be considered as inter-related markers of good quality IPA research (Nizza et al., 2021).

Construct a compelling unfolding narrative

Provision of a strong and engaging narrative or story is key in conveying the findings to the reader in a manner that is both engaging and readily understood (Nizza et al., 2021). Each theme and sub-theme are introduced briefly to give a sense of the findings of the theme, to help set the scene. The narrative from this study emerges in different ways. In Chapter 7, each participant's individual experience is reflected through their own words, moving beyond description to a deeper level of meaning and interpretation. I recognised the importance of using carefully chosen extracts from the participants transcript allows specific points – or parts – to be highlighted, whilst remaining linked to the 'whole' of the individuals lived experience, which is a key characteristic of IPA (Smith et al., 2022). The intent in the presentation of the findings is to communicate the meaning made by my interpretation (or making sense) of the participants sense-making of their experience. Group Experiential Themes (GETs) have been developed following the interpretation and thematic comparison of the participants individual experiences. As such it is beholden on me as the researcher to ensure a sense of coherence is presented through careful selection of quotes, as the narrative moves from one participant to another. The narrative provided in Chapters 7 and 8 therefore alternates between the voice of the participants, and my voice as the researcher and analyst. The provision of clear signposting and commentary for the reader highlights the key points as well as contrasting or different perspectives as they emerge.

Developing a vigorous experiential and / or existential account

IPA employs a phenomenological approach and so is concerned with a person's experience of a particular phenomenon of interest. In particular, IPA is concerned with understanding how a person makes sense of a significant experience, one which has particular meaning to them (Smith et al., 2022). The challenge of achieving 'good' IPA work was being able to ensure that I brought out important observations of the participants experience which convey meanings that are impactful or important to

them. It was important that to pay particular attention to what they reported or spoke of, whilst sensitively engaging with interpretative process to make meaning of their own meaning-making.

Close analytic reading of participants' words

IPA involves an interpretative approach, aligning to Heidegger's hermeneutic phenomenology (Smith et al., 2022). As the analyst, I was required to employ the double hermeneutic to make sense of the meaning of the participants experience (Smith and Nizza, 2022). Meaning, in the context of the participants experience, can be discovered in different ways during the analytical stages. As well explicitly through the participants spoken words, more latent meaning can manifest through the use of metaphors, tone of voice, or use of language or tone (Gil-Rodriguez, 2022b). Reflective of IPA's interpretative tenet, as the researcher I needed to consider the meaning in the part of the extract of interest but also in relation to the context of the whole transcript (Nizza et al., 2021), thus allowing an incremental understanding of the experience to emerge. Through close engagement and attention to the data, the significance is brought to the attention of the reader through the presentation of carefully chosen quotes, which are accompanied by my interpretive comments. It is my intention that the findings are presented in a transparent manner which promotes trustworthiness.

Attending to convergence and divergence

IPA requires the analysis and interpretation of data from a group of participants who share the experience of the phenomenon (Smith et al., 2022), in this instance the experience of transitioning into an ACCP role from a critical care nurse role. This study has given attention to the shared experiences across the participants, illustrating the similarities and differences between them. In Chapter 8, the findings narrative considers the shared and convergent features, as well as representation of idiosyncratic or divergent experiences for participants. I have endeavoured to privilege each individual, so the readers appreciate their personal lived experiences. Care has been taken to provide clear analytic commentary to allow the narrative to make sense to the reader. In doing so, this allows them to partake in their own interpretive meaning-making, which Smith et al. (2022) suggest is a third hermeneutic level, or the triple hermeneutic.

Careful consideration and application of the differing but complimentary quality frameworks have confirmed the transparency and integrity applied during this study. In addition, this thesis provides compelling evidence of other strengths to the research, which will now be discussed, before acknowledging possible limitations.

Study strengths

This qualitative research presents findings from a small study, providing a strong insight into the phenomenon of interest. As such it is not the intention to claim the results to be generalisable. However, the findings are potentially transferable to other similar roles or settings, and so could be of value to advanced practitioners, senior leaders and educators.

The methodological approach (IPA) and methods employed have facilitated the achievement of the aim and objectives of the study. Through adhering to the key tenets of IPA, a strength is that this study demonstrates the characteristics of a 'good IPA' study (Nizza et al., 2021; Smith, 2011a). The idiographic focus has enabled the research to be centred on each individual's experience. This is only possible because of the openness and honesty of the participants recalling their lived experiences. The eight nurses provided rich and informative accounts, which are influential in understanding the phenomenon of interest. The sampling strategy allowed for participants from diverse regions of the UK which reduced the risk of potential regional or organisational influences dominating the findings.

Study limitations

It is inherent that I, as the researcher, acknowledges possible limitations of the study. This helps to promote confidence and trustworthiness in the findings. The findings presented reflect the narratives shared by the participants, and my interpretations of those narratives. As such they could be considered a snapshot of their experiences which has temporality due to the transient and changeable nature of the social, professional and personal factors. What may result from this is that the findings as presented may not be as the participants expect or recognise if they are looking at them at a different time.

The participant sample was self-selecting in response to an advertisement. Whilst geographical spread was achieved, there was a lack of diversity regarding participant ethnicity. It was not an objective of the study to directly investigate this element of their identity, although any shared experience offered by the participant would have been included in the data analysis process. As the participants did choose to volunteer for the study, there is a risk that they may have done so due to having extreme experiences or an issue they sought to air. However, even if this was the case, it is still acknowledging that this is their own idiographic lived experience and so would be just as valuable to explore

This study was intentionally focussed on nurses who undertook the ACCP role. It is recognised that other professional groups, such as physiotherapists, paramedics and pharmacists are also in ACCP posts. Whilst some of the concepts emerging from the findings may be applicable – such as those related to

professional hierarchy's, power, etc. - some findings are distinct to the essence of nursing practice and nursing identity. This may limit how the research impacts in the wider field of advanced practice.

As part of the expectations of doctoral study, as single researcher I conducted all data collection and analysis. Research undertaken by a team offers the opportunity for alternative interpretation and perspectives which could alter or enhance the findings. However, by working alone, a consistent approach to data analysis was taken, thus removing potential variability. I recognised that it was important to mitigate the risks of bringing any preconceptions to the data analysis and interpretative stages. Transparency was maintained through careful record keeping of all stages of the process. Additionally, sharing my progress, decision making and findings throughout the study with my supervisory team provided feedback and insights which enhanced my research practice and strengthened my work.

Final thoughts

At the start of the doctoral process, I had a question which was unrefined but generated a level of curiosity in me: why would an experienced nurse in critical care want to undergo more challenging training and education to become an ACCP?

As a critical care nurse and an advanced practice educator, I already had some insights and perceptions which I have been continuously revising as the study progressed. The resulting research has led to many personal, professional, academic and empirical discoveries and knowledge. I am not directly involved with the academic or clinical preparation of nurses moving into ACCPs. However, completion of this doctorate will enable me to broaden my own professional practice as a Course Lead and educator for a general advanced practice programme. I am cognisant of the challenges experienced by nurses moving into a new advanced practice role, and feel I am better equipped to recognise how to support them.

This thesis has been produced between myself and the participants, through the shared experience and interpretation of their lived experience. I have been a key part of this research process, bringing my own experiences and perspectives to the study as it evolved. I have reflected and considered my own positioning throughout the study, evidenced through excerpts of my reflexive journal. During this doctoral experience, I have utilised my personal, professional and academic resilience and self-awareness, diarising moments of clarity and uncertainty, achievements and times which were more challenging. Reflecting on reaching key stages, getting feedback from supervisors, challenges resulting

from workload and other stressors has allowed me to monitor and recognise the changes in both my thesis progress but also myself as a researcher.

The findings from this study offer insight and interpretation of the lived experience, as it was shared by the participants. I cannot make the claim that this is a universally shared perspective, but it does offer new understandings and knowledge which can inform future experiences. It is inherent that further exploration and understanding of the motivations and experiences of future advanced practitioners is undertaken.

Finally, it is important that workforce provision responds to meet the requirements of complex modern healthcare requirements. Key to this are advanced practice nursing roles which require competent, safe expert practitioners who possess key knowledge and skills for practice but also convey their professional nursing heritage identity and habitus to provide optimum care for their patients and populations.

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Appendices

Appendix 1: Example(s) of data charting form

Citation	Main aim/ purpose of paper	How does the author do this?	Theoretical frameworks?	What are the main findings?	How does this relate to wider literature or contribute to the research question?
Aagaard, K., Sorensen, E.E., Rasmussen, B.S. and Laursen, B.S. (2017) Identifying Nurse Anaesthetists' professional identity. *Journal of PeriAnesthesia Nursing,* 32(6); pp.619-630 Denmark	To explore professional identity of registered nurse anesthetists (RNAs) and RNAs' expectations of their professional self To explore the expectations RNAs meet from interdisciplinary team members when preparing patients for general anesthesia.	Focussed ethnography - chosen as it was to explore a specific context/ setting Setting: Hospital; anaesthesiology (two different clinical specialities). RNAs – 1 ½ years of training 4 phases to study: • Phase 1 - observation of practice environments/ role in general. • Phase 2 - observation of practice; patient interviews. 10 RNAs and 10 patients. • Phase 3 - additional interviews of 3 RNAs and 3 patients to ensure data saturation. • Phase 4 - interviews with 3 RNAs, 3 anesthesiologists and 3 OR nurses. Questions influenced by analysis of data from previous phases. Data analysis – using concepts from GT. Coding to get core variables and subcore-variables.	None specifically. Briefly discusses PI in nursing - starts in nurse education; dynamic process; enculturation into the workplace. In discussion, introduces concept of emotional labour (Theodosius, 2008)	Core variable: ***Identifying the professional self***. Discusses 'leaning on doctors' discipline'- working on delegated responsibility. Anaesthetist states importance of RNAs maintaining nursing identity, rather than identifying with medicine. Expectations that the RNAs justify their position as nurse whilst meeting expectations of new role ('semidoctor'). Two subcore variables: • Subcore 1- ***gliding between tasks and structures*** (relates to actual role processes). Production and effectiveness as team member. Recognition of others' skills. Ensuring patient focus and relationship whilst undertaking role requirements. • Subcore 2 - ***depending on independence***. Relates to having professional independence whilst working under delegated responsibility. Different perspectives of what dependence and independence was.	Considers workplace culture as a factor when nurses working in advanced level roles Culture of workplace and professional relationships important in positioning selves and forming identity of role Shows disparity in how different professionals see their PI – as nursing, or more aligned to medicine Tension between 'technical' and skills 'vs' nursing and patient centered care elements of role, and how this impacts on identity Some conflict with professional values RNA role has some similarities to ACCP role (defined educational preparation; competencies; main responsibilities aligned to medical role, etc.)

Citation	Main aim/ purpose of paper	How does the author do this?	Theoretical frameworks?	What are the main findings?	How does this relate to wider literature or contribute to the research question?
Anderson, H., Birks, Y. and Adamson, J. (2020) Exploring the relationship between nursing identity and advanced nursing practice: an ethnographic study. Journal of Clinical Nursing, 29 (7-8); pp.1195-1208 UK (England)	To consider relationships between professional nursing identity and advanced practice This will be done by exploring intra-professional relationships between ANPs and other nursing colleagues in a primary care setting	Ethnography (critical) – justified as the study was to explore what is happening, and how and why; to look at cultures and behaviours Setting: two GP sites (detail given re organisations/ size variations) Data collected via interviews, as well as observations. Researcher also kept notes/ reflexive diary. Data collected over 7 months Topic guide for interviews based on a priori theoretical concepts. Also developed iteratively during data collection (observations) Purposive sampling. ANPs (=9) and nursing colleagues (=5) ANPs 1 in training; up to 20 years' experience with others. Analysis – framework analysis. Raw data analysed (constant comparative approach). Then coded against a priori concepts in SIT and PT. Bamberg's three level positioning analysis (data coded at character, audience, and societal levels) and SIT (individual, relational and group levels).	Social identity theory (SIT) (Tajfel & Turner, 1986) Positioning Theory (PT) (Davies and Harré, 2000). Both discussed with justification for appropriateness to this study. McNeil et al (2013) - Potential identity threat triggers (5 types of triggers which can threaten PI)	Three themes: ***Conciliating Nursing*** Development of positive relationships with other nurses, driven by ANPs, even where negative behaviours encountered. Negotiating intra-professional behaviours ***Vertical Discounting*** Behaviours and views of nurses towards ANPs, undermining them or discounting them. Also undertaken by ANPs towards other nurses. Used to differentiate professional space; to position the other group negatively so their position is enhanced. ***Lateral Othering*** ANPs expressing negative views towards other ANPs. Positioning of themselves against others related to perceived competence, role remit, quality etc. Often, having biomedical knowledge/ skills seen as more valuable and better.	Discussions around SIT, professional identity and Position Theory is applicable to nurses moving into ACCP roles (and other AP roles) Explores how identity needs to be considered and embedded within a wider team as well as within the role itself Do ACCPs consider that they have a group/ PI identity? Focus is on intra-professional (nurse to nurse/ ANP) relationships; offers consideration as to why there could be a shift in the relationship Explores perception of the positionality of an advanced level practitioner – introduces concept of 'in between' or 3rd space identity

Appendix 2: Ethics letter of approval

Faculty of Health, Education & Life Sciences Research Office
Seacole Building, 8 Westbourne Road
Birmingham
B15 3TN

HELS_Ethics@bcu.ac.uk

01/Feb/2022

Ms Sharon Bishop

sharon.bishop4@mail.bcu.ac.uk

Dear Sharon ,

Re: Bishop /#9747 /sub2 /R(A) /2022 /Jan /HELS FAEC - The lived experience of critical care nurses transitioning into an Advanced Critical Care Practitioner role - an Interpretative Phenomenological Analysis

Thank you for your application and documentation regarding the above activity. I am pleased to take Chair's Action and approve this activity.

Provided that you are granted Permission of Access by relevant parties (meeting requirements as laid out by them), you may begin your activity.

I can also confirm that any person participating in the project is covered under the University's insurance arrangements.

Please note that ethics approval only covers your activity as it has been detailed in your ethics application. If you wish to make any changes to the activity, then you must submit an Amendment application for approval of the proposed changes.

Examples of changes include (but are not limited to) adding a new study site, a new method of participant recruitment, adding a new method of data collection and/or change of Project Lead.

Please also note that the Health, Education and Life Sciences Faculty Academic Ethics Committee should be notified of any serious adverse effects arising as a result of this activity.

If for any reason the Committee feels that the activity is no longer ethically sound, it reserves the right to withdraw its approval. In the unlikely event of issues arising which would lead to this, you will be consulted.

Keep a copy of this letter along with the corresponding application for your records as evidence of approval.

If you have any queries, please contact HELS_Ethics@bcu.ac.uk

I wish you every success with your activity.

Yours Sincerely,

Dr. Annalise Weckesser

On behalf of the Health, Education and Life Sciences Faculty Academic Ethics Committee

Appendix 3: Recruitment advertisement

BIRMINGHAM CITY University

Are you an Advanced Critical Care Practitioner?

I am seeking registered nurses with critical care experience who have transitioned into an ACCP role, to volunteer to participate in this research study which is being conducted as part of my PhD at Birmingham City University.

Project Title: The lived experience of critical care nurses transitioning into an Advanced Critical Care Practitioner role – an Interpretative Phenomenological Analysis.

This study seeks to explore how nurses experience the transition into the ACCP role, how they make sense of this transition and the impact on their professional identity and positionality within the wider team. The role of the ACCP is gaining an increasing evidence base however the experience of making the decision and moving into such a role remains unexplored within the literature. It is anticipated that this study will support future critical care nurses considering undertaking the ACCP role, as well as informing managers, senior clinicians, and healthcare organisations with ACCP workforce planning.

Inclusion criteria

You must:

- Be a registered nurse who has completed the FICM ACCP course and are now in a substantive ACCP role
- Have a minimum of 6 months experience within the substantive role (not including training period)
- Be actively in practice currently (e.g., not long-term leave of any kind)

An interview will be arranged via MS Team at a date / time to suit yourself. This will last approximately 30-60 minutes. Your confidentiality and anonymity will be maintained throughout the research process. Further detailed information can be found in the Participant Information Sheet. A completed Consent Form will be required prior to the interview.

Please contact the lead researcher, Sharon Bishop, for more information, or to express your interest in taking part and I will email the Participant Information Sheet and Consent form to you: sharon.bishop@bcu.ac.uk

Thank you for your consideration and time in reading this.

Appendix 4: Participant Information Sheet (PIS)

Date: 21/01/2022
Version: 2.0

Participant Information Sheet

Study title: The lived experience of critical care nurses transitioning into an Advanced Critical Care Practitioner role – an Interpretative Phenomenological Analysis.
Aim of the study: The aim of this study is to explore the experiences of critical care nurses who have transitioned into the role of an Advanced Critical Care Practitioner (ACCP).

Invitation to participate in a research study
I would like to invite you to participate in an interview as part of the above-named study. This study is part of a PhD project being undertaken by myself (Sharon Bishop) at Birmingham City University.
It is important that you understand why the research is being undertaken and what it would involve for you to agree to participate. The purpose of this Participant Information Sheet is to provide you with more information about the research project so that you can decide whether you would like to consent to take part. You are welcome to discuss this with others if you wish. If there is anything you would like to clarify or if you would like to discuss this further with myself, please contact me directly.

What is this research about?
The purpose of this study is to explore the experiences of critical care nurses who have chosen to undertaken formal education and training to become an Advanced Critical Care Practitioner. The transition process to a new professional role can involve a change to the individual's professional context. This may require the person to undergo adjustments in regard to their role, identity, relationships, and their positionality within the wider healthcare team. A scoping review of the literature identifies research which has studied the transition of professionals moving into advanced practice roles across a range of healthcare environments. However, there is limited research which considers this within modern Critical Care teams, and there is no empirical data relating to the transition of nurses becoming ACCPs. The purpose of this research study is to explore and gain insight of your experience of becoming an ACCP, how you experienced the transition, and how this impacts on your own perception of your role, professional identity, relationships, and your place within the wider healthcare workforce.

Why have I been invited?
You have been invited to take part in this study because you have completed your ACCP qualification. This study seeks to gain the participation of a range of ACCPs working in different organisations so that varied accounts of the lived experience of this transition can be discovered and appreciated.

Do I have to take part?
Participation in this study is completely voluntary and so it is up to you to decide to take part. If you would like to proceed, I would ask that you complete, sign, and return the consent form (provided alongside this information sheet) prior to the interview taking place. You can sign the form electronically, or print, sign and scan it for return via email. Alternatively, you can take a photo of the form and return this if easier. If neither of these options are possible, I would request that you email from your work email, confirming that you have read the information provided and state that you are consenting to take part in the study. Your consent should be given if you are satisfied you are fully informed about the study process. I will confirm your consent again verbally when we meet for the interview.
If you do agree and consent to participate but later change your mind or if your circumstances change, you still have the right to withdraw from the study without penalty or consequence. If the interview has taken place, you can change your mind and withdraw from the study within four weeks of the

interview (at which point the interview will be transcribed and you will have been offered the opportunity to receive a copy of the transcription). After this timescale, your interview data will still be included; this will continue to be used with complete confidentiality and anonymity as set out below. If you decide not to participate in this study this will not result in any further action or contact from myself, and I am grateful for your time in considering this.

What will I have to do?
If you consent to participate, I will contact you directly through email to arrange a mutually agreeable date and time for a semi-structured interview. This type of interview will be guided by a broad pre-determined set of topics or questions, but it also aims to ensure that you have the freedom to discuss your experience. I will ask you questions around your clinical experience, your decision to apply and train as an ACCP, and how the transition into the role has been experienced by yourself. I will also seek to gain some background demographic information about you as well as professional background information (for example, the length of experience within your nursing and ACCP role, and your qualifications).
It is my intention to conduct the interview via MS Teams. You would need to ensure you can access and use a computer or other device which has the capacity for accessing MS Teams, and in particular the audio and video functions. Ideally this should be a private location where you will be unlikely to be interrupted or overheard. It is important you feel able to talk freely and confidentially. Please note that due to ethical approval guidance, I cannot interview you if you are on NHS premises. If you are not familiar with MS Teams, I can provide you with a simple guidance sheet. The interviews will last approximately 30- 60 minutes and will be recorded via MS Teams to allow transcription of our interview to occur. You will be offered the opportunity to receive a copy of the transcript. All information you give me will be treated in the strictest confidence and anonymised so no one will know what you have said (please see section on confidentiality later in this document).

What happens to the data collected from me?
The interview will be transcribed verbatim before analysis occurs. Data analysis will be guided by Interpretative Phenomenology Analysis methodology in order that key themes are identified. The data and themes from individual participants will be considered in relation to each other so that similarities and differences of the lived experiences can be discovered. This will then form the basis of the PhD thesis.

What are the possible disadvantages and risks of taking part?
I do not anticipate any specific risks to yourself by taking part in this study. Care will be taken to ensure you are comfortable during the interview. However, it is important to acknowledge that we will be speaking about your experiences and feelings, and so it is possible that during the interview you may discuss issues which may trigger an uncomfortable memory or emotional response. If this occurs you will be offered a break(s) from the interview, and I will offer you support (or help you to identify an alternative source of support via your organisation). If there is a particular question or topic you would rather not answer, then that will be respected. You will be free to end the interview at any point if you feel you cannot or do not want to continue.

What are the possible benefits of taking part?
The aim of this study is to contribute to the knowledge base around this topic area. You may not benefit personally from participating but the sharing of your experience will provide information that will be valuable to other groups. For example, it is hoped that it will benefit future critical care nurses considering undertaking the ACCP role to be more aware of the potential benefits, challenges and wider considerations when transitioning into this specialist advanced practice role. It will help to inform critical care senior clinicians and managers, as well as Trust senior groups through providing

insight into elements of workforce and organisational development that is currently not addressed in the literature.

Will my taking part in the study be kept confidential?
Yes. All personal data and study information will be managed in accordance with the General Data Protection Regulations (GDPR, 2018) and Data Protection Act (2018). All information about yourself and the data collected will be anonymous. You will be allocated a unique participant identification number (P.I.N.) as soon as consent if given and only I will know which participant identifier number relates to you. Only your P.I.N. (not your name or initials) will used on all documents or files relating to your participation in this study. Other potentially identifying data, such as the name of your employing NHS Trust will not be used explicitly. Examples of direct quotes from interviews may be used within the final PhD thesis and these will be referred to by using a pseudonym for each participant.

All files will be stored securely in a designated BCU student OneDrive folder as per BCU's Research Integrity standards, and only I will have access to this folder. No copies of any data or documents pertaining to your participation will be stored elsewhere. All data or documents will be kept in accordance with BCU's policy on Data Retention which abides by GDPR (2018) and the Data Protection Act (2018). BCU will retain evidence of your participation in this study through the signed consent form for up to three years after the project has been completed (estimated date of completion early 2025). Therefore, we anticipate retaining some of your personal data up until 2028 at which point it will be destroyed as indicated in this policy.
Anonymity and confidentiality of your participation will remain during and after the study has been completed. The only exception to this would be if information is disclosed during the process which raises concerns of potential harm or patient safety or would be deemed to be in breach of the Nursing and Midwifery Council Code (2018). This would be identified with you at the time, and further guidance would be sought from my PhD supervisors. This may necessitate me to report my concerns through your employing Trust's policy (for example Conduct or Fitness to Practice), or to the Nursing and Midwifery Council directly.
If at any time you have concerns or questions about your data and how it is being managed which I have not been able to address, you can contact the Data Protection Officer for Birmingham City University via email - informationmanagement@bcu.ac.uk or +44 (0)121 331-5288 or Data Protection Officer, Information Management Team, Birmingham City University, University House, 15 Bartholomew Row, Birmingham, B5 5JU. Alternatively, you can complain directly to the Information Commissioner at Information Commissioner's Office, Wycliffe House, Water Lane, Wilmslow, Cheshire, SK9 5AF, further information available at www.ico.org.uk

What will happen to the results of the research study?
It is anticipated that the findings will be published and presented at conferences. It is hoped that an article for publication will also be generated. The findings may be shared as appropriate within and externally to BCU, for example within research forums or professional groups. The final completed PhD thesis will be available on the British Library catalogue website. You will be asked after the interview whether you would like to receive a written summary of findings via email once the thesis is completed.

Who is organising and funding the research?
This is an independent PhD study; no funding has been sought.

Who has reviewed this research study?
This study is being undertaken under the supervision of Dr Barbara Howard-Hunt and Professor Ann-Marie Cannaby. The research has been scrutinised and approved by BCU's Faculty Research Committee on 1st February 2022.

Contact details

Primary researcher:
Sharon Bishop (PhD student)
School of Nursing and Midwifery; Faculty of Health, Education and Life Sciences.
Rm. SCT 380; City South Campus; Westbourne Road, Birmingham; B15 3TN.
Phone: 0121 202 4548
E-mail: sharon.bishop@bcu.ac.uk

Supervisors:
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School of Nursing and Midwifery; Faculty of Health, Education and Life Sciences.
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Professor Ann-Marie Cannaby
Chief Nurse, The Royal Wolverhampton NHS Trust.
Wolverhampton
WV10 0QP
Phone: 01902 695889 (85889)
E-mail: ann-marie.cannaby@nhs.net

What if there is a problem or if I have a concern?

If a problem arises as a result of, or in connection, with the research please contact me in the first instance. You may also contact my Supervisors (details above). If you have a concern or complaint regarding the process, you can contact the Faculty Ethics team via email - HELS_Ethics@bcu.ac.uk

If you would like to take part in this study, or if you have questions about this study which are not addressed in this information sheet, please contact me (Sharon Bishop) on the email above.

Thank you for taking the time to read this Participant Information Sheet.

Appendix 5: Participant Consent Form

PARTICIPANT CONSENT FORM

Study title: The lived experience of critical care nurses transitioning into an Advanced Critical Care Practitioner role – an Interpretative Phenomenological Analysis.

Name of researcher: Sharon Bishop

Project Code:	*Participant identification number:*
PhD-H 1718-03 SB 0190	i.e. P1, P2 etc.

Please read each of the following and initial against each statement to confirm your consent.

1. I confirm that I have read and understood the Participant Information Sheet [21/12/2021; Version 1.0] for this study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily.	
2. I understand that my participation is voluntary and that I am free to withdraw no later than four weeks following the interview without giving any reason, without penalty or consequence.	
3. I understand that if I withdraw my consent more than four weeks after the interview, my data will still be processed and used within this study. My data will be treated within the parameters set out in the Participant Information Sheet [21/12/2021; Version 1.0] to ensure confidentiality and anonymity is maintained.	
4. I understand that demographic data about me will be collected for the purposes of the research study including name and professional qualifications and experience, and that these will be processed in accordance with the information sheet [21/12/2021; Version 1.0].	
5. I understand that relevant sections of my data collected during the study may be looked at by individuals from Birmingham City University and from regulatory authorities where it is relevant to my taking part in this research. I give permission for these individuals to have access to my data.	
6. I agree to the recording of the interview, and the use of anonymised quotes or other data in the final thesis or other reports / publications.	
7. I understand that in the event that information is disclosed that may my suggest harm to any person, it will be necessary to inform my Supervisors in the first instance, and if required to inform an appropriate manager and / or regulatory body.	
8. I agree to take part in this study.	

Name of Participant	Date	Signature	Email address

Name of Researcher	Date form received from participant	Signature	Date consent checked and confirmed (interview date)

Appendix 6: Interview guide

Interview schedule – researcher copy

RECORDER ON

Introduction
Confirm consent
Begin main interview

	Question
1	Can we begin with you telling me a little about what the ACCP role is? Prompt(s): Can you tell me a little more about your main role and responsibilities? A typical day? How long you have been doing this for?
2	Before you moved into the ACCP role, you worked as a critical care nurse – can you tell me a little more about this part of your professional experience? Prompt(s): How long were you in a critical care nursing role(s) for, before commencing the ACCP role? What qualifications did you gain during your time as a critical care nurse? Can you describe the parts of that role that you particularly enjoyed? What were the challenges or the less satisfactory elements of working in critical care nursing?
3	Can you describe your reasons for making the decision to transition from your critical care nursing role into an ACCP role? Prompt(s): Can you say more about your reasons for making that decision at that point of your professional career? Can you recall having any worries or concerns about making this change at the time?
4	Looking back at that time, what were your experiences of the actual transition from your nursing role, through the training period, to becoming a qualified ACCP? Prompt(s): Were there any difficulties or challenges that you encountered? What strategies or actions have you found helpful? Can you recall any particular examples of this?
5	From the point of deciding to transition into the ACCP role, can you tell me about your professional relationships with others in the team, and whether you think these changed? Prompt(s): Did you feel any relationships changed, either for the better or the opposite? Can you explain / give an example? How do you think your colleagues who worked with you as a critical care nurse perceived your move from a nursing role to the ACCP role? How do you think colleagues perceive your professional identity now?
6	Thinking about the wider organisation, management level and above, do you think they understood the ACCP role and how it differs from the critical care nursing role? Prompt(s): Can you recall anything that happened (or even didn't happen) which may have impacted on your experience of transitioning into the ACCP role? Can you recall any conflict, challenges or dilemmas from your seniors as a result of your move into an ACCP role?
7	You remain a Registered Nurse on the NMC register. How would you describe your professional identity now you are in the ACCP role?

	Prompt(s): Can I ask if you still feel like a nurse in relation to your day-to-day clinical practice as an ACCP? [If yes] - Can you give an example / explain this? - Can you describe any elements of your current practice which you feel are particularly aligned or attributed to being a registered nurse? [If no] - Can you explain why you don't see yourself as a nurse anymore?
8	If you were asked for your advice by a critical care nursing colleague who was thinking about moving towards an ACCP role, what would be the main considerations that you could give them to support their decision making? Prompt(s): Are there any particular recommendations you could make? Do you think the transition of nurses now may be different from your experience? If so, can you explain why?
9	Is there anything you were expecting to be asked about that didn't come up today? Prompt(s): Is there anything that we've discussed that you'd like to go back to? Is there anything else you'd like to add?

Closing the interview

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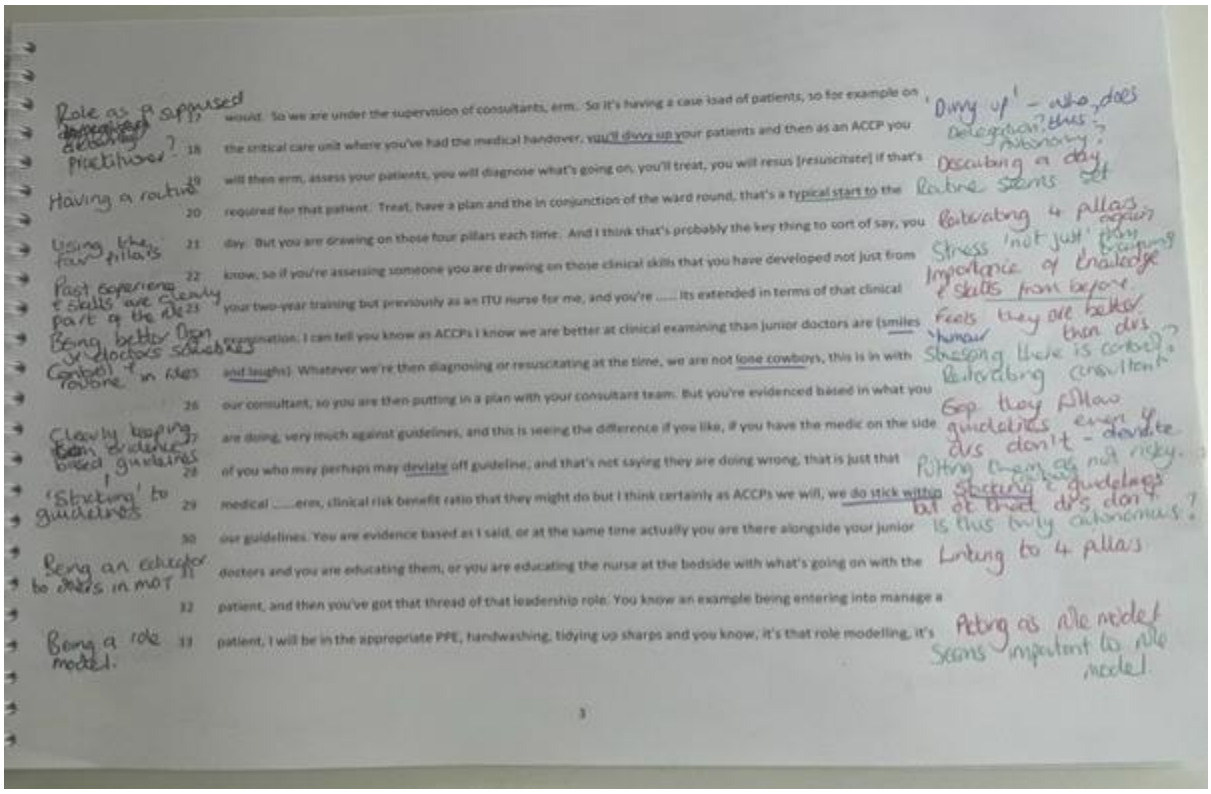
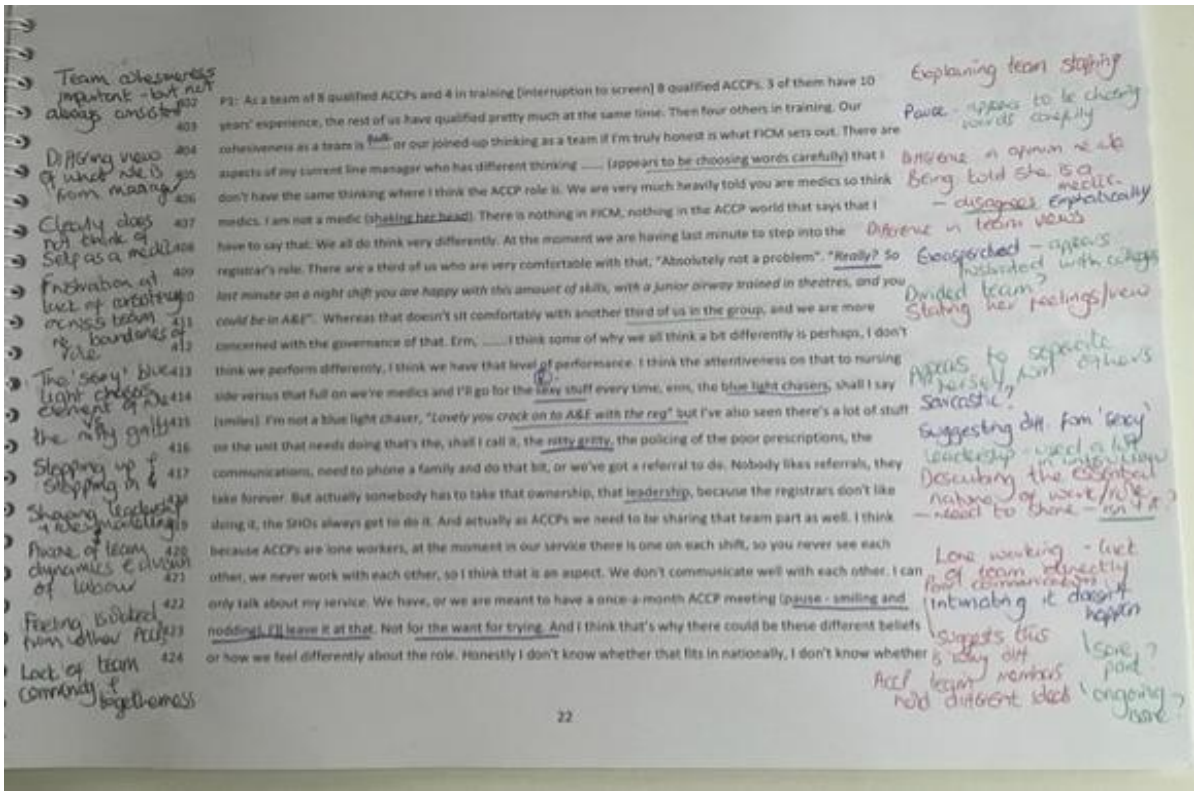
Appendix 7: Example of initial noting and formation of experiential statements (Anna's transcript)



would. So we are under the supervision of consultants, erm. So it's having a case load of patients, so for example on the critical care unit where you've had the medical handover, you'll divvy up your patients and then as an ACCP you will then erm, assess your patients, you will diagnose what's going on, you'll treat, you will resus [resuscitate] if that's required for that patient. Treat, have a plan and the in conjunction of the ward round, that's a typical start to the day. But you are drawing on those four pillars each time. And I think that's probably the key thing to sort of say, you know, so if you're assessing someone you are drawing on those clinical skills that you have developed not just from your two-year training but previously as an ITU nurse for me, and you're ..... its extended in terms of that clinical examination. I can tell you know as ACCPs I know we are better at clinical examining than junior doctors are (smiles and laughs). Whatever we're then diagnosing or resuscitating at the time, we are not lone cowboys, this is in with our consultant, so you are then putting in a plan with your consultant team. But you're evidenced based in what you are doing, very much against guidelines, and this is seeing the difference if you like, if you have the medic on the side of you who may perhaps may deviate off guideline, and that's not saying they are doing wrong, that is just that medical .....erm, clinical risk benefit ratio that they might do but I think certainly as ACCPs we will, we do stick within our guidelines. You are evidence based as I said, or at the same time actually you are there alongside your junior doctors and you are educating them, or you are educating the nurse at the bedside with what's going on with the patient, and then you've got that thread of that leadership role. You know an example being entering into manage a patient, I will be in the appropriate PPE, handwashing, tidying up sharps and you know, it's that role modelling, it's



P1: As a team of 8 qualified ACCPs and 4 in training [interruption to screen] 8 qualified ACCPs, 3 of them have 10 years' experience, the rest of us have qualified pretty much at the same time. Then four others in training. Our cohesiveness as a team is [laugh] or our joined-up thinking as a team if I'm truly honest is what FICM sets out. There are aspects of my current line manager who has different thinking ..... (appears to be choosing words carefully) that I don't have the same thinking where I think the ACCP role is. We are very much heavily told you are medics so think medics. I am not a medic (shaking her head). There is nothing in FICM, nothing in the ACCP world that says that I have to say that. We all do think very differently. At the moment we are having last minute to step into the registrar's role. There are a third of us who are very comfortable with that, "Absolutely not a problem". "Really? So *last minute on a night shift you are happy with this amount of skills, with a junior airway trained in theatres, and you could be in A&E*". Whereas that doesn't sit comfortably with another third of us in the group, and we are more concerned with the governance of that. Erm, ...I think some of why we all think a bit differently is perhaps, I don't think we perform differently, I think we have that level of performance. I think the attentiveness on that to nursing side versus that full on we're medics and I'll go for the sexy stuff every time, erm, the blue light chasers, shall I say (smiles). I'm not a blue light chaser, "*Lovely you crack on to A&E with the reg*" but I've also seen there's a lot of stuff on the unit that needs doing that's the, shall I call it, the nitty gritty, the policing of the poor prescriptions, the communications, need to phone a family and do that bit, or we've got a referral to do. Nobody likes referrals, they take forever. But actually somebody has to take that ownership, that leadership, because the registrars don't like doing it, the SHOs always get to do it. And actually as ACCPs we need to be sharing that team part as well. I think because ACCPs are lone workers, at the moment in our service there is one on each shift, so you never see each other, we never work with each other, so I think that is an aspect. We don't communicate well with each other. I can only talk about my service. We have, or we are meant to have a once-a-month ACCP meeting (pause - smiling and nodding). I'll leave it at that. Not for the want for trying. And I think that's why there could be these different beliefs or how we feel differently about the role. Honestly I don't know whether that fits in nationally, I don't know whether

Appendix 8: Selection of Anna's Personal Experiential Themes and sub-themes

PET 1 Sub-theme 1.1: Waiting for the ACCP role	Waiting for the ACCP role	*So I think, erm, it was always something I wanted to do for years and years before. I always wanted that role. It was something muted around for like, three decades*	150-152
PET 1 Sub-theme 1.1: Waiting for the ACCP role	A long process to become an ACCP • Happy to wait due to loyalty and wanting to stay with employer • Is being comfortable with an employer laziness? • Wanting to have had the role earlier in career	*So I've had a longer journey than most in a bit of an ambulatory way (wavy movement in hands).* • *So for me that's why, the waiting was really, the Trust that I work in, I've invested a lot in over the years, in that Trust. Equally them back to me.* • *Some of it is laziness, some of its, it's comfortable staying where you are. I am very comfortable with my consultant body, and I knew that they would be supportive of the role* • *I would have loved this role to have come 15 years ago, I would have done. That would have been great.*	110 154-155 157-159 433-434
PET 1 Sub-theme 1.2: The learning journey – challenges and opportunities	Being proactive and getting on with it • Recognising need to revisit previous learning again • Driven to be the best she could	*So you have to adapt, you basically had to adapt and I had to honestly say the first year was probably about pulling your pants up and really thinking about adult learning yourself, because there wasn't the "I'm going to hold your hand and this is what I needed to be handed to on this date".* • *I hadn't been able to practice those skills. So actually I didn't feel credible just to say yeah, I'm going to APL out of that aspect. So I redid my clinical examinations, I hadn't done diagnostics, so I redid my diagnostics.* • *the thought of failing and not getting a good grade for me on the university side didn't sit well with me. I think other people were like "I'm just happy if I pass". I'd love that (laughs) because they are right, you just need to pass it (laughs). So I suppose it all depends on the individual pressure you put on yourself for academic achievement*	213-216 117-119 458-461
PET 1 Sub-theme 1.2: The learning journey – challenges and opportunities	Frustration at not having a good start to the role • Having to set up own training processes before getting some structure and support • Showing commitment to the role by having to use own time for training at the beginning	*So I started my training programme knackered already, and slightly annoyed that, ahh, you know, Let's do this portfolio on my days off, and you don't always find you get that rich learning as you are already disgruntled that you are coming in on your days off.* • *We had two other Band 6's previously as nurses coming into trainee positions. That …… allowed us three Band 7s to be very vocal (laughs) trying to lead it in the way we thought the training should be. Then we had an education supervisor who is a Consultant, who then gave us some structure.* • *But because the university modules on clinical examinations and diagnostics started before our training post officially started, and we had to develop a portfolio of fifty patients, the first 3 months running up to that I had to find all my patients on my days off*	189-191 195-197 186-188

PET 1 Sub-theme 1.3: The essence of her ACCP role	The ACCP role as a product of all her previous knowledge and skills • Past experience and skills are clearly part of the role • Using nursing knowledge to add to role and be able to see things differently • Breadth of prior experience important for role • Lack of appreciation of junior / new nurses to ACCP role, and her nursing experience	*So yeah, my experience is not two years in training as an ACCP then just post qualifying as an ACCP. I've got 30 years in ITU that I can share with the ITU nurse alongside the junior doctor.* • *….you are drawing on those clinical skills that you have developed not just from your two-year training but previously as an ITU nurse for me* • *…….the medic may come along and assess the patient for respiratory failure, assess and go, "Well we have got poor air entry here". I'll look at the patient and go, "Well they will because the nurse has got him at 25 degrees on the bed. Let's sit him up, let's get him up the bed, let's get him doing a cough, lets change those tapes". "Well I haven't got a nurse around me". "Well I can do that".* • *And I think if you haven't had that exposure to those different levels of situations, the delirium person versus the cardiac arrest patient, the formal complaint to the praise, of what's it like working in a team* • *what we've not done is educate them as to the role of the ACCP and what we were before, as in nurses before. We do know nursing, let us help you. "Oh, you won't know how to do this on an ITU patient", "Oh, no no we do (laughs), I'll tell you now we do".*	348-349 22-23 360-363 447-449 280-283
PET 1 Sub-theme 1.3: The essence of her ACCP role	Balancing clinical and cognitive skills • Decision making – a core requirement for role • Reality of being the decision maker • Being better than junior doctors sometimes • Recognising the reality of the role is not generally the advanced clinical skills	*There are skills like that, those skills (holds hands to eye level to show high). There are the decision-making skills.* • *you do need to be able to make decisions. And you can learn knowledge. You can do the EPALS course, and 3 months later I can forget it all. But I need to be able to make decisions* • *Yeah that is right isn't it, we should do that?* • *I can tell you know as ACCPs I know we are better at clinical examining than junior doctors are* • *Absolutely loved it (hand on heart), thought it was amazing, I was on cloud heaven for ages. Can I remember any of it now? No, that was 3 months ago (laughs). Is it a skill I really need to have? It was a nice thing to do that day, it was great (smiles). But, no, otherwise not.*	83-84 445-446 87 24 390-392

PET 2 Sub-theme 2.1: Keeping control of the role	Controlling the pace of changing her practice role • Having control and routine in the role • Comfort in feeling she could ask for help • Comfortable with supervision	*so you can run before you can walk. It is a bit like your prescribing. when you first prescribe, it is recommended to have your top 10 prescriptions. So you can, ……erm, play safe, you can understand that role.* • *we are not lone cowboys, this is in with our consultant, so you are then putting in a plan with your consultant team.* • *But equally I knew where to go to for help to say, "Do you know what, how do I get out of this situation?", or "Teach me on this", or "I don't know this", or whatever.* • *I'm very comfortable being supervised, erm, to intubate. I'm not rushing to get that additional qualification to intubate unsupervised*	67-69 25-26 160-162 76-77
PET 2 Sub-theme 2.1: Keeping control of the role	Sticking to guidelines • Sticking to guidelines as an ACCP • Clearly keeping to evidence based guidelines	*as long as you learn a structure, if I follow that guideline of EPALS, I've got the skills of clinical assessment, examination, following an algorithm, following a guideline* • *but I think certainly as ACCPs we will, we do stick within our guidelines* • *But you're evidenced based in what you are doing, very much against guidelines*	103-104 29-30 26-27

	• Not deviating from job role and scope of practice	• *My advanced practice roles should be, and hopefully are, covered by my vicarious liability of my JD. So that's where I sit very comfortably. As long can demonstrate within my portfolio the four pillars and don't deviate out of that*	341-343
PET 2 Sub-theme 2.2: Fear and anxiety – still not fully comfortable with the role	Fear and anxiety – still not fully comfortable in ACCP role	*There are still shifts I go to work, and I feel physically sick thinking, err, actually will I be good enough today. There are other shifts that I come away thinking, That was a really good shift, and other shifts where I still wake up at 4 o'clock in the morning and think, Why did I say that? Do that? Prescribe that? (laughs) err, Not do that?*	168-171
PET 2 Sub-theme 2.2: Fear and anxiety – still not fully comfortable with the role	Reality shock • Being overwhelmed • Stepping out of comfort zone and feeling like a novice again • The reality of the role	*It's like a massive explosion* • *Because it is like an **explosion** of a role (hand gesture to show explosion).* • *Started on my ACCP journey and all of a sudden things I thought I knew I didn't actually quite know (change in voice tone – surprised tone). Things I did know I then forgotten. And then there were some things, oh my God, I didn't even know that ever, about anatomy, physiology, the pathway, the journey for the patients.* • *it's the actual doing it. The four o'clock in the morning.*	73 69 70-73 88
PET 2 Sub-theme 2.3: Shifting professional relationships	Being treated and supported differently by nurse leaders and senior doctors • Lack of professional relationships or input from nurse manager/ leadership level colleagues	*And what was so interesting now being on that very different side was, so I had a Matron saying, "I will investigate this and found out exactly", to my consultant who I informed went, "No way you've would've spoken to them badly, I absolutely know how you are. I have all the confidence in your work. You've documented all of that. I'll make sure it's me who communicates with them".* • *Honestly, they [nurse manager/ leaders] don't interact with us. They don't interact with us, they have nothing to do with us.*	324-327 311
PET 2 Sub-theme 2.3: Shifting professional relationships	Loss of personal connection with medical team colleagues compared to nursing colleagues • Noticing a shift in gender balance	*there is no fluffy talking, there's no "Oh god I had a really shit day at home yesterday". They don't want to know. And you get that, and that is quite lovely in nursing as that helps you on your day. You don't always get that on the medical side. You have to find it. I can go through a whole day of not talking to medics about anything but something very clinical.* • *At the moment, medicine and ITU is still very male dominated, and I've certainly felt the difference from moving from a very female workforce to a very male workforce.*	470-473 467-469

PET 3 Sub-theme 3.1: The ACCP role in bringing the team together	The ACCP role in bringing the team together	*So the one aspect is that it is a very wonderful role understanding both parts.*	359-360
PET 3 Sub-theme 3.1: The ACCP role in bringing the team together	Building trust and collaboration of nurses	*Or even that junior nurse developing, and those that are underconfident will call for help and actually they will call the ACCP first before they call the registrar now.*	368-369
PET 3 Sub-theme 3.1: The ACCP role in bringing the team together	Being aware of the needs of others - empathy	*there is still the delirious patient that probably is useful for my, and I've clocked that and I can see it, I can see the frustration of the nurse.*	395-396

PET 3 Sub-theme 3.2: Reflecting on team dynamics	Reflecting on team dynamics	*But maybe that's what you need in an ACCP team, you need that difference, you need that balance, you need that sort of constant smouldering fire going on with an ACCP, …… erm, making sure the status quo is still going, and another ACCP that's "Rah, I'm off with my blue light to see that A&E patient"*	435-438
PET 3 Sub-theme 3.2: Reflecting on team dynamics	Positioning herself as different from other ACCP colleagues • Troubled by ACCP colleagues' bravado approach to the role	*they do like to bang on about them and their skills, and maybe it's my age, maybe it's my past leadership. I don't need to do that. I need to know I am safe, that the units safe* • *There is a lot of bravado with ACCPs. '"Yeah, I did that. Tubed this kid in A&E the other day". "Did you?" Well for me I'm like that's not what the policy says* • *(Bravado of other ACCPs): And there some out there that will say to you .... there's a lot of bravado in the ACCP world.*	431-432 425-426 98-99
PET 3 Sub-theme 3.3: The future for the ACCP role	The need for good leadership for the ACCPs • Lack of clear team leadership was frustrating • *Lack of understanding and communication as to what the role is* • *Differing views than her line manager as to what the ACCP role is* • *The constraints in being able to do other elements of the role*	*what the vision of your service is and then being very clear I think through visionary leadership, and that's not necessarily just me, that's about your own leader, your clinical director who's governing your service.* • *We didn't have an ACCP lead, we had another manager within our service who ……, what's the word, ……. the only vision that individual had (laughs) was the fact that it ticks a box that we have ACCPs in training.* • *And so there wasn't great communication about what who we were, what we were, what our learning needs were.* • *There are aspects of my current line manager who has different thinking ……. (appears to be choosing words carefully) that I don't have the same thinking where I think the ACCP role is.* • *(but you have to give me time, and I'm not given any time to sort any of this out.*	50-51 191-193 209-210 404-406 492-493
PET 3 Sub-theme 3.3: The future for the ACCP role	Recognising the need for change in the ACCP role and service • Longevity of the role but in what form? • The strain of meeting the demands of the role • ACCPs in the future – the risk of burnout due to unclear workforce plans / strategies	*I think that's the thing moving forward, because these services will change and morph and that's another aspect, you have to realise they will change and morph. So is then that still the role for you, or the service for you, or the Trust for you.* • *I think it will be a role in ITU now. It's just what it morphs into in time* • *But we are in danger of burning ourselves out being something of everything as an ACCP* • *when we talk about where ACCPs are going, a lot of people go, "Oh yeah we need them, it's going to be really part of the service". There are so many consultants being burned out at the moment. ACCPs, I think, there is a real risk that that could quite easily happen for a number of reasons. There's still a lot of blanket warming and hugging that still needs to be done around the role as well (laughs), with careful thinking.*	513-515 62 373-374 171-175

Appendix 9: Initial clustering of sub-PETs

Placing the individual sub-PET themes into initial clusters

Examples of sub-themes from seven participants – initially 'labelled' as Planning, preparing, getting started

Personal Experiential Theme 1	**A cautious and planned decision**
Sub-theme 1.1	Wanting an advanced role

Personal Experiential Theme 1	**Making it happen – the beginning of his ACCP role**
Sub-theme 1.1	Almost natural to move his practice forward to an advanced level

Personal Experiential Theme 1	**A cautious and planned decision**
Sub-theme 1.2	A well-considered plan to get the ACCP role

Personal Experiential Theme 1	**Setting out – the start of her ACCP journey**
Sub-theme 1.1	Saw this as a clear and definite opportunity

Personal Experiential Theme 1	**Moving towards a new role**
Sub-theme 1.1	The driving forces for his decision

Personal Experiential Theme 1	**Developing towards being an ACCP**
Sub-theme 1.1	Preparing for the role

Personal Experiential Theme 1	**The process of becoming an ACCP**
Sub-theme 1.1	Waiting for the ACCP role

Personal Experiential Theme 1	**An uncertain, uncomfortable but welcome opportunity**
Sub-theme 1.1	An opportunity to leave a stagnant career

Appendix 10: Assigning individual Experiential Statements to emerging group themes

Planning, preparing, getting started

The realism of the potential of the role • Seeing the potential opportunity • Wanting to be an advanced clinician in practice • Clarity regarding what he wanted in his career • The need to do more in his role	*So that really got me …… opened my eyes to look, there is people doing advanced practice, nurses doing advanced practice that traditionally were medical roles and this was something that really excites me.* • *… really enlightened and opened my eyes to advanced practice* • *the ACCP role really demonstrated you could be an advanced clinician and do clinical practice* • *and really wanted to do clinical practice, advanced clinical practice, in preference to nursing management.* • *but sort of felt there was a bit more I needed to do*	146-148 *150* *74-75* *90-91* *80*
Almost natural to move his practice forward to an advanced level	*it was a natural progression* *So it was almost a natural*	137-138 141
Motivated by seeing how others had undertaken the role • Very confident that this was the right role for her career • A positive encounter with other AP roles excited her • She was self-directed to start working towards an AP role	*I saw the advert and thought 'Oh my gosh, these people are actually…'* *So I was like "Oh wow".* • *I knew it was for me. It had my name on it.* • *what I really saw was they used advanced practice nurses loads at the ROH, and specialist nurses and things. Their reliance on them was huge* • *So I went off and did my health assessment masters module and non-medical prescribing [NMP] myself*	162 166 193 8-9 12-13
Waiting for the ACCP role	*So I think, erm, it was always something I wanted to do for years and years before. I always wanted that role. It was something muted around for like, three decades*	150-152
Aligning the best parts of his past roles to the ACCP role	*when I left me Outreach and got back into my ITU job I felt constrained again a little bit, because I was managing a shift or sitting in an office doing that. But then this role now, I'm part of the cardiac arrest team, I'm part of the trauma team. I go and see sick patients on the ward, make referrals, you know, implement treatment on the wards. So it is back to doing the outreach like, but with a bigger hat on*	169-173
A strong career history within critical care nursing • A strong history in critical care nursing	*so I did do every grade and different roles* • *I absolutely loved it, and I thought then this is what I want to do*	132-133 3-4
Saw this as a clear and definite opportunity	*so actually it was the ideal job. And you never know when these opportunities would come around again. So it was an opportunity to take*	141-142
Excited to think about getting this role • Appears to feel lucky to get the role – concerned if it had been more widely open • Gender as a factor when applying for the trainee role	*when the ACCP role came about, it's the only time that my eyes lit up and I felt butterflies in my tummy (tone picks up, smiling a lot) for my career again actually.* • *Yes, I was lucky. The post wasn't advertised externally when I went for it. So it was very much in-house.* • *when I applied there was only one boy out of the thirty applicants in the group that had applied, which I thought was really interesting, I thought there would have been more.*	80-81 45-46 135-136

Appendix 11: Extract from cross-case analysis prevalence table

Planning / preparation	Anna	Alex	Victoria	Frances	David	Isobel	Matthew	Emily
The potential of role		x					x	
Oh wow' - motivated / excited			x					x
Feeling alone – no-one around who had done it / being a pioneer					x		x	
Fulfilment		x						
Wanting to do more for pts	x	x						
Loving critical care - wanting to stay there / CC not superficial care		x			x		x	
Not wanting to be stuck / being stuck / feeling constrained / feeling stagnant / tied down			x		x	x		
Staying 'hands on' / staying in clinical practice		x	x		x			
Not wanting Matron role / office role / senior	x	x	x		x			x
Career pathway for senior nurses	x					x		
Natural progression							x	
Active in putting role together/ driving it /							x	
Being assertive to get a new ACCP role elsewhere						x		
Taking a time to get role set up / a slow start	x					x	x	
Wanting the role for a long time	x						x	
Opportunity – to go for the role		x	x	x	x	x		
Accidental opportunity to apply for the role								x
Becoming uncomfortable to get/ do the role		x						
Needing it to fit in with personal life	x							
Being reassured prior to applying (helping confidence)		x		x				
Being prepared/ scoping it out first		x						
Being prepared/ ensuring the right course		x						
Self-directed to do some modules (to help towards role)								x
Sacrificing - making changes to do the role		x						
Being lucky to get it			x					
Realises should have done studying sooner			x					
Reluctant student / push of academia		x			x			
Do I or don't I? / nothing to lose/ safety net		x				x		
Knowing she could go back to nursing role if needed			x					
Burning need - could I do it?	x							
Needing confidence to go for it (interview)		x						

Reality - transition	Anna	Alex	Victoria	Frances	David	Isobel	Matthew	Emily
Lack of self-belief / confidence						x		
Lack/ change of confidence - during transition					x			x
Starting again- being stripped back re skills					x	x		
Having to set own training up / Training - lack of guidance	x			x				
Needing to form scope/ guidelines for role					x			
Self-motivation for learning opportunities						x		
Realising lots to learn					x			
Commitment/ motivation - using own time	x							
Challenge in getting skills during training				x				
Needing to be selfish to do role		x						
Changing own mindset - recognising time to 'knuckle down' in role			x					

Adapt - pull your pants up / adult learning initiative	x							
Recognising the change in self and responsibilities			x					
Taking responsibility for decisions / Decision making as core skill for role	x		x				x	
Embrace the role - take responsibility			x					
Intense to have close scrutiny during training / Scrutiny - pressure					x	x		
Being watched / challenged made him better in role					x			
Training - needing time to consolidate				x				
Hard but be better practitioner / better prepared						x		
Challenges hard but positive						x		
Training hard but rewarding						x		
Strategy for getting confidence up - being systematic			x					
Transition takes time - building it back up.					x			
Expectations - big jump from trainee to qual. ACCP		x						
Long-term commitment to role and learning			x					
APs elsewhere in org had paved the way re barriers							x	
Support from senior trainees / qual ACCPs				x		x		
Peer support during training				x		x		x
Support during course important			x					
Lack of formal support networks for new role							x	
Being a lone trainee hard							x	
Realising not completely out of depth at university			x					
Recognising own experience was not good compared to current trainees	x							
Pandemic - accelerated learning	x							
Redeployment (Covid) affected skills / confidence				x				
Covid - going back to nursing role but happy with that			x					

Appendix 12: Extract of final clustering pre-confirmation of GETs

[Nb – the labels in Maroon represent clustering of the key words/ themes from the experiential statements, which sit underneath]

NEW GET: 'An explosion of a role' – navigating the transition	Anna	Alex	Victoria	Frances	David	Isobel	Matthew	Emily
(Planning / preparation) Drivers / motivations	Y	Y	Y	y	Y	Y	Y	y
Fulfilment		x						
Wanting to do more for pts	x	x						
Loving critical care - wanting to stay there / CC not superficial care		x			x		x	
Not wanting to be stuck / being stuck / feeling constrained / feeling stagnant / tied down			x		x	x		
Staying 'hands on' / staying in clinical practice		x	x		x			
Not wanting Matron role / office role / senior	x	x	x	x	x			x
Career pathway for senior nurses	x					x		
Natural progression							x	
(seeing) The potential of role		x					x	
Oh wow' - motivated / excited			x					x
(Planning / preparation) Making a decision "Do I or don't I?"	Y	Y	Y	Y	Y	Y	y	y
Opportunity – to go for the role		x	x	x	x	x		
Accidental opportunity to apply for the role								x
Becoming uncomfortable to get/ do the role		x						
Needing it to fit in with personal life	x							
Being reassured prior to applying (helping confidence)		x		x				
Being prepared/ scoping it out first		x						
Being prepared/ ensuring the right course		x						
Self-directed to do some modules (to help towards role)								x
Sacrificing - making changes to do the role		x						
Feeling alone – no-one around who had done it / being a pioneer					x		x	
Being lucky to get it			x					
Realises should have done studying sooner			x					
Reluctant student / push of academia		x			x			
Do I or don't I? / nothing to lose/ safety net		x				x		
Knowing she could go back to nursing role if needed			x					
Burning need - could I do it?	x							
Needing confidence to go for it (interview)		x						
Active in putting role together/ driving it /							x	
Being assertive to get a new ACCP role elsewhere						x		
Taking a time to get role set up / a slow start	x					x	x	
Wanting the role for a long time	x						x	
(Lack of role clarity) Unclear role scope		y	y	y	y	y	y	
Lack of guidance / info re new role - no one had done it			x		x			
Finding our feet' - lack of defined role				x				
Not understanding scope - surprised by additional expectations			x					
Unclear expectations - 'not what signed up for'				x				
Varying skillset within role affecting clarity of role				x				
Limitations in role – self-imposed?				x				
Needing to establish own role inc protocols					x			

NEW GET: 'An explosion of a role' – navigating the transition	Anna	Alex	Victoria	Frances	David	Isobel	Matthew	Emily
Uncertainty re role expectations and developments				x				
Needing to break down barriers - others had helped with governance issues		x						
Intense to have close scrutiny during training / Scrutiny - pressure					x	x		
Aware of being scrutinised							x	
(Medicalised role) Control of scope			y	y		y	y	y
Scope of role grew - but dependent on medical viewpoint							x	
Early scope controlled by others							x	
Not understanding the scope of role - dictated by drs			x					
Contradictory - like jr drs, but nurses with boundaried role				x				
Need for prof. practice protection			x					
Rota's								
ACCPs must have different rota - medical rota not suitable								x
Wants own ACCP rota, not drs			x	x				
Issues with rota						x		
(Medicalised role) Positioning of role	y	y	y				y	y
Role positioned as jr dr / doctor		x					x	
First AP role was 'SHO' role								x
100% part of medical workforce								x
Part of medical workforce; but not a medic	x							
Being seen by others as one of the doctors							x	
Filling in medical gaps; being on medical rota							x	
Seen by others as a hybrid (between drs and nursing)			x					
Positioning self with medical team			x					
Feels more medical than nursing			x					
Expected to be on medical rota	x		x				x	
(Control) Safety and control of self	Y		Y	y				
'Not rogue' - seeking support and staying safe			x					
Keeping control of role	x							
Awareness of high level risk	x							
Guidelines important to keep role safe	x							
Being evidence-based	x							
Comfortable seeking support or help / Get support when needed still	x			x				
Confident to be supervised	x							
Getting feedback - some anxiety			x					
Clear about boundaries - what she will do or not do / Confidence in saying no	x							
Protection - of own scope / PIN	x							
Sees a lot of 'bravado' in other ACCP colleagues	x							
Positions self as different from ACCP colleagues	x							
(Reality – transition) Lack of structure for training	y			y	y	y		y
Having to set own training up / Training - lack of guidance	x			x				
Needing to form scope/ guidelines for role					x			
Self-motivation for learning opportunities						x		
Realising lots to learn					x			

NEW GET: 'An explosion of a role' – navigating the transition	Anna	Alex	Victoria	Frances	David	Isobel	Matthew	Emily
Commitment/ motivation - using own time	x							
Challenge in getting skills during training				x				
Acutely aware of own limitations - repeating training / Repeating earlier learning - need to be credible and safe	x							x
Recognising own gaps and limitations								x
Loss of control of training	X							
Not seeking support/ 'bumbled along'				x				
(Reality – transition) Support	y	y	y	y		y	y	y
APs elsewhere in org had paved the way re barriers							x	
Support from senior trainees / qual ACCPs				x		x		
Peer support during training				x		x		x
Support during course important			x					
(home/nursing)								
Being in new ITU - helpful as not treated as per old role		x						
Happy to stay with employer for role	x							
Saw consultants as 'friends' so some comfort in staying in same ITU			x					
(Wider team) Cons support								
Consultant relationships good - was known to them before	x							
Consultants being proactive in helping get the role established						x		
Support from consultants important			x					
(Emotions)								
(Reality – transition) Confidence			y		y	y		y
Lack of self-belief / confidence						x		
Lack/ change of confidence - during transition					x			x
Starting again- being stripped back re skills					x	x		
Strategy for getting confidence up - being systematic			x					
Transition takes time - building it back up.					x			
(fear) Emotions	y		y			y		y
'Explosion' of role	x							
Self-doubt - personality or gender?			x					
Petrified with nightmares – reality of role / Anxiety - worrying about practice	x					x		
Not worthy - low expectations of self & abilities / Expecting not to get the role			x					
Comparing self to others - who are seen as better			x					
Would be embarrassed to fail in front of own colleagues /worry of failing in front of own colleagues	x		x					
Lack of familiarity helpful -a fresh start								x
Feeling overwhelmed			x					
Worry - not clever enough						x		
Expecting a stressful and difficult time			x					
Showing humour - to offset anxiety?			x					
(Reality – transition) Mindset / realising it is serious	y	y	y				y	
Needing to be selfish to do role		x						
Changing own mindset - recognising time to 'knuckle down' in role			x					

NEW GET: 'An explosion of a role' – navigating the transition	Anna	Alex	Victoria	Frances	David	Isobel	Matthew	Emily
Adapt - pull your pants up / adult learning initiative	x							
Recognising the change in self and responsibilities			x					
Taking responsibility for decisions / Decision making as core skill for role	x		x				x	
Embrace the role - take responsibility			x					
Expectations - big jump from trainee to qual. ACCP		x						
Long-term commitment to role and learning			x					
Realising not completely out of depth at university			x					
Seeing the role was different (to nursing)			x					
Being watched / challenged made him better in role					x			
Hard but be better practitioner / better prepared						x		
Challenges hard but positive						x		
Training hard but rewarding						x		

Appendix 13: Group Experiential Themes (GETs) table

GET 1: 'An explosion of a role' – the journey to the ACCP role

GET 1: Sub-themes	(Clusters)	Anna	Alex	Victoria	Frances	David	Isobel	Matthew	Emily
The move to a new role	Drivers / motivations	Y	Y	Y	y	Y	Y	Y	y
	"Do I or don't I?": preparation / caution; proactivity	Y	Y	Y	Y	Y	Y	y	y
Power and control	Unclear role scope (inc. some of scrutiny)		y	y	y	y	y	y	
	Control of scope			y	y		y	y	y
	Cons resistance					y	y	y	
	Medical resistance/ issues	y			y	y	y		y
	Rota's			y	y		y		y
	Positioning of role	y	y	y				y	y
	Safety and control of self	Y		Y	y				
	Cons protection (positive power)		y	y	y		y		
	Lack of structure for training	y			y	y	y		y
Changing nursing dynamics	Exclusion	y			y	y	y		
	Power and resistance		y	y		y	y		
	Recognising a shift in self / on other side	y		y	y				y
	Factors for issues	y		y		y	y		
	Lack of nursing insight/ support		y	y	y	y	y	y	y

GET 2: "There to care" – negotiating their identity and place

GET 2: Sub-themes	(Clusters)	Anna	Alex	Victoria	Frances	David	Isobel	Matthew	Emily
The psychological and emotional impact	Loneliness / feeling alone	y		y	y		y	y	
	The impact of support	y	y	y	y		y	y	y
	The emotional impact of the transition: confidence; emotions	y		y		y	y		y
	Mindset / realising it is serious (inc. some of scrutiny)	y	y	y		y	y	y	
Praxis – being a nurse	Practical	Y	Y	Y		Y	Y	Y	y
	Empathy and understanding	y	y			Y	y		
	Heritage – drawing on nursing	Y	y		Y	Y	Y	Y	y
	Being in-between	y		y	y	y	y		
Establishing a sense of belonging	Strategies	y	y	Y	y	Y	Y	y	
	Positive rels - nurses	Y						Y	y
	Positive rels - drs	Y	Y			Y	Y		y
	Accepted & valued	y				Y	y		
	Being a bridge	y		y			y	y	
	Impact					Y	Y	y	
	Supporting and educating	y		y			y		

GET 3: “I think it will get better, won’t it?” – vulnerability, concern and hope

GET 3: Sub-themes	(Clusters)	Anna	Alex	Victoria	Frances	David	Isobel	Matthew	Emily
An uncertain future	Change is needed	y				y			y
	Unclear career option/pathway		y		y	y	y	y	
	The future as an ACCP	y			y		y	y	
	Protection – ACCPs / future ACCPs	y	y	y		y	y	y	y
The need for role governance and leadership	Relationships to leaders/ managers	y			y			y	y
	Organisation governance and understanding		y		y	y		y	y
	Protection (protective)– role standards		y		y	y	y	y	y
Reflections of the COVID-19 pandemic		y	y	y	y		y	y	